

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series***

## **12**

Robert G. Aukerman, M.S.W.  
Peggy McGarry  
Consensus Panel Co-Chair

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
Rockwall II, 5600 Fishers Lane  
Rockville, MD 20857

DHHS Publication No. (SMA) 94-3004. Printed 1994.

---

### Table of Contents

- [\[Front Matter\]](#)
- [Chapter 1 -- Introduction and Purpose](#)
- [Chapter 2 -- An Overview of the Criminal Justice System](#)
- [Chapter 3 -- The AOD Abuse Treatment System](#)
- [Chapter 4 -- Combining AOD Abuse Treatment and Intermediate Sanctions](#)
- [Chapter 5 -- Issues in Combining Treatment and Intermediate Sanc...](#)
- [Chapter 6 -- Planning: Approaches for Developing Policy](#)
- [Chapter 7 -- Ethical and Legal Issues1](#)
- [Appendix A -- Bibliography](#)
- [Appendix B -- Costing Issues](#)
- [Appendix C -- Cultural Competence](#)
- [Appendix D -- Federal Resource Panel](#)
- [Appendix E -- Field Reviewers](#)
- [\[Exhibits\]](#)

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System

[Front Matter]

[Title Page]

### **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

*Treatment Improvement Protocol (TIP) Series 12*

Robert G. Aukerman, M.S.W.

Peggy McGarry

Consensus Panel Co-Chair

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
Rockwall II, 5600 Fishers Lane  
Rockville, MD 20857  
DHHS Publication No. (SMA) 94-3004.  
Printed 1994.

---

### **Disclaimer**

This publication is part of the Substance Abuse Prevention and Treatment Block Grant technical assistance program. All material appearing in this volume except quoted passages from copyrighted sources is in the public domain and may be reproduced or copied without permission from the Center for Substance Abuse Treatment (CSAT) or the authors. Citation of the source is appreciated.

This publication was written under contract number ADM 270-91-0007 from the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA). Anna Marsh, Ph.D., Sandra Clunies, M.S., and Duiona R. Baker, M.P.H., served as the CSAT Government project officers.

Beth Lindeman served as project director, Sandra Trilling as TIP manager, Carolyn Davis as managing editor, and Constance Gartner as editor. Writers were Carolyn Davis, Randi Henderson, and Angela Verdelle.

The opinions expressed herein are the views of the consensus panel participants and do not reflect the official position of CSAT or any other part of the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT or DHHS is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized patient care and treatment decisions.

## **What Is a TIP?**

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal Resource Panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then transmitted to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 3 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners.

A Chair for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as Expert Field Reviewers. Once their recommendations and responses have been reviewed, the Chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment in public and private programs recognized for their provision of high quality and innovative AOD abuse treatment.

This TIP, titled *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*, provides information about the management and treatment of offenders with AOD problems through the use of intermediate sanctions with an AOD treatment component. This TIP includes specific recommendations for use by individuals and agencies in the AOD treatment and criminal justice systems to develop programs and coordinate services. The TIP provides information about the role of intermediate sanctions, the importance and role of collaboration, conflicts and solutions relative to integrating treatment with intermediate sanctions, legal and ethical issues, and information regarding planning, implementation, monitoring, and evaluation of these programs.

This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

## **Consensus Panel**

### **Chair:**

Robert B. Aukerman, M.S.W.

Director

Alcohol and Drug Abuse Division

Colorado Department of Health

Peggy McGarry

Senior Associate

Center for Effective Public Policy

Washington, D.C.

### **Facilitators:**

Margaret Brooks, J.D.

Consultant

Montclair, New Jersey

Jesse Jerry Jaramillo, B.S.

Consultant

Los Alamos, New Mexico

George M. Little, M.A.

Regional Director

Delta Probation Region  
Tennessee Department of Corrections  
Memphis, Tennessee

**Workgroup Members:**

Gene R. Boyle, M.A.

Director of Program Services  
Office of Drug and Alcohol Programs  
Pennsylvania Department of Health  
Harrisburg, Pennsylvania

Mark Fontaine, M.S.W.

Assistant Director  
Florida Alcohol and Drug Abuse Association  
Tallahassee, Florida

Honorable Kathleen R. Gearin

Judge, Second Judicial District  
St. Paul, Minnesota

Leo Hayden, Jr., B.A.

Director of Special Projects  
TASC, Inc.  
Chicago, Illinois

Don Hogner, B.A.

Chief Probation Officer (Ret.)  
Alameda County Probation Department  
Fresno, California

Robbie Jackman, M.S.S.W.

Assistant Commissioner

Bureau of Alcohol and Drug Abuse Services

Tennessee Department of Health

Nashville, Tennessee

Tranice Diazell Jackson, M.D.

Chief Physician, AMKC

Montefiore/Rikers Island Health Services

Manalapan, New Jersey

Jane H. Martin, M.B.A.

Director

Risk Reduction Programs

Division of Mental Health, Mental

Retardation, and Substance Abuse

Department of Human Resources

Atlanta, Georgia

Roger H. Peters, Ph.D.

Assistant Professor

Florida Mental Health Institute

Department of Law and Mental Health

University of South Florida

Tampa, Florida

Susan Powers, J.D.

Deputy District Attorney

Kings County District Attorney's Office

Brooklyn, New York

## **Foreword**

The Treatment Improvement Protocol Series (TIPs) fulfills CSAT's mission to improve alcohol and other drug (AOD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. This guidance, in the form of a protocol, results from a careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates employs a consensus process to produce the product. This panel's work is reviewed and critiqued by field reviewers as it evolves.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. I am grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

Susan L. Becker

Associate Director for State Programs

Center for Substance Abuse Treatment

Your browser does not support JavaScript

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Chapter 1 -- Introduction and Purpose**

As the Nation moved from the 1980s into the 1990s, two major national trends emerged within criminal justice: the war on drugs and the use of intermediate sanctions. Upon examination, they are found to be related: Much of the interest in intermediate sanctions has been fed by the direct impact of the drug war on State and local courts and corrections. Sanctions -- that are less restrictive than incarceration but more restrictive than simple probation -- are thought to be an effective response to the increased volume of drug-related cases coming into the system. A very high percentage of offenders whose crimes are drug related have substance use disorders or dependency and need substance abuse treatment.

It is appropriate, then, that the Center for Substance Abuse Treatment has directed the preparation of this Treatment Improvement Protocol (TIP) to address the use of intermediate sanctions with offenders whose crimes are related to their alcohol and other drug (AOD) abuse. Expectations are very high that intermediate sanctions can be structured and utilized to realize benefits for both the community and the offender: They can punish crime and treat its cause at the same time. Efforts to combine AOD abuse treatment with intermediate sanctions could have enormous significance for communities around the Nation that have been torn apart by drugs and their side effects. The success of those efforts depends on the continued cooperation of those who work within the treatment and criminal justice systems.

The members of the consensus panel who have produced the chapters that follow hope that this TIP will serve as a vehicle to enhance that cooperation. The TIP is a consensus document, developed from a week-long set of discussions that drew on the experience of the panel members. They represented the diverse legal, correctional, medical, educational, research, supervision, and treatment aspects of the joint venture between the criminal justice system and the AOD abuse treatment system. As the panel pursued its deliberations, consensus grew on the need for fuller understanding among everyone involved in providing AOD abuse treatment for offenders of the goals, dilemmas, restraints, and opportunities within the two systems and how these affect the common effort. These guidelines are aimed at increasing and enhancing

understanding, cooperation, and interest in the use of intermediate sanctions among offenders with AOD abuse problems.

Understanding, cooperation, and interest are, of course, only preludes to action. The TIP guidelines also recommend specific steps that individuals and agencies in the two systems should take to coordinate more effectively the tools and resources that each brings to the task of treating individuals and maintaining them as safely and constructively as possible outside a correctional institution in the community. Some steps involve case management to handle individual cases; others describe necessary system-to-system contact, information sharing, and coordination.

## The Interest in Intermediate Sanctions

In describing the contemporary landscape in which jurisdictions are working to combine intermediate sanctions and effective AOD abuse treatment, certain trends must be understood. These include:

- More people than ever before are being incarcerated, for longer periods of time.
- More State and local funds are being spent on prisons and law enforcement than ever before.
- A growing percentage of crime is related to AOD use and abuse.
- People are more concerned about crime and more afraid of becoming a crime victim now than they were in even the recent past.
- The criminal justice and AOD abuse treatment systems serve a disproportionately large number of persons from minority groups.
- Increasing numbers of persons with special needs are served by the criminal justice and AOD abuse treatment systems, including, for example, elderly and HIV-infected persons, pregnant women, and mentally ill AOD abusers.
- Resources will always be limited.

It is against this backdrop that interest in intermediate sanctions has flourished. For some, these sanctioning options represent the right approach to sentencing: They include many criminal justice system policymakers who want the ability to do individualized sentencing, to be able to respond appropriately and effectively to the diversity of offenses and offenders presented to them. The interest of others is driven by profound dissatisfaction with the outcomes of most existing sanctions, including prison, jail, and probation, particularly in light of their cost. Dissatisfaction with current sanctions is probably most profound in cases that involve drug- and alcohol-abusing offenders. Even the less serious crimes that these offenders typically commit -- burglary, robbery, purse-snatching, small-scale drug sales -- induce fear and are ruinous to a community's sense of itself. Policymakers' greatest dismay is that the intervention of the criminal justice system seems to have little or no effect: The same offenders appear in court time after time. At the same time, the costs of prison, jail, and probation are draining the coffers of State and local governments at a growing rate.

Others, including both criminal justice officials and a considerable portion of the public, believe that these options are necessary because there is simply not enough money to build enough prisons to incarcerate all offenders. In fact, intermediate sanctions programs combined with

AOD abuse treatment have been shown to be a more cost-effective approach to the Nation's crime and substance abuse problems than long-term incarceration.

The public is beginning to understand that being jailed or imprisoned is not the only possible consequence of criminal behavior. Intermediate sanctions and AOD abuse treatment are also consequences, and both require accountability. Recent public opinion studies conducted in a variety of States, including Colorado, Delaware, Alaska, and Alabama, have indicated that the public may be more open to these ideas than are many elected officials. The public is beginning to accept creative approaches, even for serious offenses, and accepts the idea of restitution or meaningful community service as well as treatment as appropriate measures of accountability for certain criminal actions.

---

*In fact, intermediate sanctions programs combined with AOD abuse treatment have been shown to be a more cost-effective approach to the Nation's crime and substance abuse problems than long-term incarceration.*

---

These expectations of intermediate sanctions -- that they will be more effective, cost less, and present no increased risk to the public -- are terribly high and perhaps even unrealistic. They stand virtually no chance of being met, however, unless jurisdictions can match the sanction with the offense in a way that will meet the connected goals of protecting the community, rehabilitating (or habilitating) the offender, and holding individuals accountable for their behavior.

The matching of offenders and sanctions in the service of specific goals demands that the use of intermediate sanctions be policy driven. Creating policy requires interagency collaboration: Judges, prosecutors, criminal justice agencies, and treatment groups have to choose the goals that are appropriate for offenders, become educated as to what sanctions are available to them, and then reach agreement on which sanctions are most likely to achieve the goals.

## **Defining Intermediate Sanctions**

*Sanctions* are legally binding orders of the court or paroling authority that deprive or restrict offender liberty or property. An *intermediate sanction* is any sanction that is more rigorous (unpleasant, intrusive, or controlling) than traditional probation but less restrictive than total incarceration.

In many jurisdictions, public and private agencies have already created a wide variety of intermediate sanctioning programs and options. With the advent of new technologies for assessment and supervision of offenders, new methods of intervention and treatment, and an increased understanding of targeting programs to particular populations, the capability of those agencies to manage offenders safely and to treat them effectively in the community has expanded as well.

The difficulty for many jurisdictions is that the term *intermediate sanctions* is used to refer both to specific sanctioning options or programs and to the overall concept of a graduated range of sentencing choices guided by articulated policy that directs their most appropriate use. Creating intermediate sanctions requires the development of a range of sanctioning options and a coherent policy to guide their use.

---

*Sanctions are legally binding orders of the court or paroling authority that deprive or restrict offender liberty or property. An intermediate sanction is any sanction that is more rigorous (unpleasant, intrusive, or controlling) than traditional probation but less restrictive than total incarceration.*

---

There is further confusion created when particular programs or options are used for *pretrial populations*, that is, for those who have only been charged with but not convicted of a crime. In that case, the court may order a defendant to participate in a treatment program or report to a day reporting center (for example) as a *condition of release* while he or she is awaiting trial. Under that circumstance, the program is not truly an intermediate sanction, but a form of pretrial supervision.

The particular programs or forms of sentencing that comprise a jurisdiction's intermediate sanctioning options can be whatever the policymakers of that jurisdiction decide that they need and can afford in order to meet their goals for their offender population. Some of the more widely used options are described in [Exhibit 1-1](#). AOD abuse treatment may be combined with any of these sanctions to achieve the goal of more effective sentencing for drug-involved offenders. *It is important to understand, however, that each jurisdiction, whether a State, a county, or a court district, will have developed its own version of these, and that from area to area, programs may share a name and little else.*

Jurisdictions around the country are using a wide variety of intermediate sanctioning options and inventing new ones. As described below, these sanctions are employed or imposed at various points in the criminal adjudication and disposition process. However, they are rarely used alone. They are typically imposed in a package, and often are part of a so-called "split sentence" (that is, a short -- 1 to 6 months -- period of incarceration combined with time under supervision in the community). A particular offender, for example, might be ordered to serve a short term in jail and, after release, to observe a strict curfew, attend a day treatment program, and perform a specified number of hours of community service each week.

## **The History of Intermediate Sanctions**

There is nothing inherently new in intermediate sanctions. Private agencies, probation departments, parole agencies, corrections departments, and community corrections agencies have for many years operated programs with special features designed to make them more intense than "typical" probation or parole, but less intrusive than incarceration: Work release centers,

halfway houses, intensive supervision, supervised furloughs, community service, and community treatment programs have been used for decades.

The development of community-based corrections programs gained momentum in the 1960s and 1970s. The increase in funding for social programs and the optimism about dealing with poverty and social problems that characterized much of that period also influenced criminal justice. The creation of the Federal Law Enforcement Assistance Administration (LEAA) in the early 1970s meant the addition of many millions of dollars each year for the development and operation of new community-based offender treatment and training programs.

Following a period of fairly localized program development, several States organized and funded community corrections as a separate branch of corrections and a distinct sentencing option in the mid-1970s. Kansas, Colorado, Iowa, Minnesota, and Oregon developed community corrections acts during this time.

While each jurisdiction was -- and is -- different, the motive behind these initial efforts was the belief that many offenders, particularly those with short criminal histories and no record of violence, could be dealt with more effectively in the community than in an institution. The underlying assumption was that the purpose of sanctioning was to make offenders less likely to commit more crime, chiefly through treatment and training. Individual communities were seen to be the best judges of appropriate responses to their own offenders and, therefore, the most appropriate treatment sites.

In the 1980s, a number of other States, including Tennessee, Michigan, and North Carolina, created community corrections programs. Other States began experimenting with intensive supervision probation, electronically monitored house arrest, and boot camps. The difference between these and earlier efforts was the emphasis in the 1980s on punishment and increased control of offenders, as opposed to treatment and training. To gain support, new community-based programs had to prove how tough and unpleasant they were. At the same time, States were passing laws creating mandatory minimum prison sentences for a wide variety of crimes; escalating the penalties on most crimes, especially those involving drugs; and making an increasing number of offenders ineligible for nonincarcerative sentences. The so-called war on drugs, as waged by legislatures and law enforcement and prosecutorial agencies, was part of this fundamental shift in criminal justice policies. According to surveys of the Nation's 75 largest counties by the Department of Justice, the percentage of felony convictions resulting in prison sentences increased consistently and dramatically in the last half of the 1980s, while the percentage resulting in probation sentences declined. The largest increase in prison sentences was for drug-trafficking offenses. In 1990, 71 percent of felony convictions in State courts overall resulted in a sentence to prison or jail ([Bureau of Justice Statistics, 1990](#)).

The emphasis on control, supervision, and surveillance of offenders in the 1980s resulted in the development of new or enhanced technologies to achieve those objectives. Probation and parole agencies devised objective risk assessment instruments to measure the level of risk that groups of offenders represented, and used the results to develop the most effective supervision strategies for each group. With the development of easy and relatively inexpensive methods of chemical testing, screening offenders for the use of illicit drugs became routine at arrest and as part of

offender supervision. Several different technologies have been deployed to monitor the movement of offenders in the community using electronic devices attached to the offender, a telephone hook-up, and computers signaled by the devices.

Throughout the 1980s, the call for increased offender accountability and punishment also resulted in the development of community service, day fines, and restitution programs whose emphasis is on making the offender "pay his (or her) debt" to society. Many of these programs emphasize difficult and/or unpleasant manual labor, often performed in public places. Boot camps have also surged in popularity.

This shift in emphasis from treatment and training to punishment, surveillance, and control means that as we approach the mid-1990s, many jurisdictions have a fairly broad range of types of sanctioning options in place that are designed to meet many different goals. At the same time, corrections agencies and courts are beginning to understand the power of information technology to help them manage their operations and pinpoint the kinds of offenders in their system. A well-designed information system can give a local or State criminal justice system very specific data on its offenders and can help its policymakers make informed choices about the most effective use of existing and yet-to-be-created sanctioning options for its offender population.

## **AOD-Involved Offenders And Intermediate Sanctions**

As policymakers examine the use and benefits of intermediate sanctions in their systems, the offenders that they typically identify first as potential candidates for such sanctions are drug- and alcohol-abusing offenders. Those on the front lines of the system -- judges, prosecutors, probation officers, and defense attorneys -- are expressing their frustration at the ineffectiveness of a "punish and control" approach with AOD offenders. They are fueling, and in many cases leading, the demand for a range of sanctioning options that contains: first, programs that provide AOD abuse treatment that can be used as a component of a sentence or sanction, and, second, options that permit them to respond to relapse without sending the offender to jail or prison. Their demands arise not out of a desire to hold offenders less accountable or less subject to appropriate control, but rather from a belief that only effective treatment will reduce offenders' propensity to commit future crimes, and thus increase public safety.

Federal, State, and local legislatures are responding. Increased funds are being allocated for treatment, and in some places, greater discretion to use these sanctions is being returned to judges. Prosecutors' offices and courts are establishing so-called "drug courts" to divert low-level AOD offenders to treatment before they are adjudicated.

## **Overview of This Tip**

This Treatment Improvement Protocol fosters cooperation between the criminal justice system and the alcohol and drug abuse treatment field to address the use of intermediate sanctions with offenders whose crimes are related to their AOD abuse. Intermediate sanctions can be structured and used to realize benefits for the community and the offender by punishing crime and treating its cause at the same time.

Bringing about the cooperation and collaboration required to combine sanctions and treatment requires the joint efforts of the legal, correctional, medical, educational, and treatment fields, as well as continuing research efforts. For the benefit of all these fields, the TIP uses a fundamental and logical approach to provide basic overviews of the criminal justice system and the AOD abuse treatment system ([Chapters 2](#) and [3](#), respectively).

The TIP then proceeds logically to describe the processes of combining the two systems in local areas ([Chapters 4](#) and [5](#)). This is followed by a discussion of major issues that will face planners in developing a cooperative criminal justice and treatment approach to intermediate sanctions ([Chapter 6](#)). Specific planning approaches for developing policy at the local level are provided. The TIP concludes with a discussion of the ethical and legal issues involved ([Chapter 7](#)).

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Chapter 2 -- An Overview of the Criminal Justice System**

Successful collaboration depends on clear understanding. This chapter briefly explains pertinent processes and purposes of the criminal justice system to those who work in the alcohol and other drug (AOD) abuse treatment field. [Chapter 3](#), following, explains AOD abuse treatment to those in the justice system.

Each system has its own standard operating procedures and nomenclature. Each uses and depends on processes and words that may be confusing to the other. To work together effectively to ensure that offender-clients in need of treatment receive appropriate services, the two systems must understand each other's professional purposes and language. To those outside of criminal justice, for example, probation and parole are hard to distinguish from each other, while "intervention" has one meaning in the treatment field and another in criminal justice.

This chapter and the one that follows are provided to help readers in each field understand both the terminology and the steps in the processes that are integral to the practice of the two disciplines. Greater clarity can help establish the effective working relationships that are so necessary to attaining the shared goals of these systems. Whether probation officer or counselor, judge or treatment administrator, the desired end is safer communities, and the work of both systems is essential to its achievement.

### **The Goals and Purposes Of the Justice System**

Any introduction to the criminal justice system must begin with a review of sentencing philosophies. These philosophical principles, also called sanctioning purposes, are rooted in hundreds of years of Western thought and law, and are part of most discussions of sanctioning both in individual cases and in the development of larger system policies. These *purposes of sanctions*, defined briefly below, are often interwoven in everyday usage with a set of *values* that guide their implementation. The purposes of sanctions and values surrounding them must coexist with *system goals* that are also brought to bear in decisionmaking.

What are commonly called the goals of sanctions are articulations of the reasons why a society chooses to respond in particular ways to criminal behavior.

## **Retribution or Punishment**

Retribution justifies sanctions as the earned punishment for transgressing the law. It is founded on the belief that members of a community have an obligation to obey the laws of that community and that anyone who breaks the law deserves punishment. *Unlike all other purposes of sanctions, retribution does not aim to use the occasion of sentencing to achieve some future good result for the society.* Punishment is meted out because a wrong has been committed and the transgressor must pay. A balance has been tipped (by the offense) and must be righted (by the punishment).

The philosophical underpinnings of this approach are many. Some philosophies focus on the importance of treating each individual as a responsible member of the community to be held accountable for his or her own behavior. Others focus on the societal need to expound community standards of behavior and to reinforce their importance by the act of condemning and punishing violations.

Retribution focuses primarily on the act committed in the offense. Punishment is based on the seriousness of the crime, rather than on the good that the sanction might do for the offender (such as treating an addiction or teaching a skill) or for the community (such as removing a potentially dangerous offender from the community). Neither estimations of future risk nor sanctions based on efforts to address that risk play a role in retribution.

## **Rehabilitation**

Rehabilitation, incapacitation, and specific and general deterrence are utilitarian philosophies of sentencing. They rest on the principle that society is justified in inflicting pain and unpleasantness on its members only if some future good for the larger society is realized from the act: In the case of crime, sanctioning criminal behavior will result in less crime in the future and, therefore, in enhanced public safety.

Rehabilitation is based on the view that the most productive approach to preventing criminal behavior is to diagnose and treat its underlying causes in the individual. This view obviously has its roots in a theory of criminality that traces criminal behavior to some physical, emotional, or social problem of the individual offender.

To be effective, rehabilitation depends on several essential ingredients: a reliable means of assessing offenders' needs, a prescription for responding effectively to the assessment, the resources to respond adequately to the offenders' needs, and the knowledge that responding in this way will affect the individual's proclivity to commit crime.

The availability of resources remains one of the most common problems in implementing a rehabilitative approach to sanctions. When it is possible to determine the kinds of treatment, education, or other assistance that would benefit a given offender or groups of offenders, the resources are often not available. Typically, resources for such services for the noncriminal population are inadequate, making it even more difficult to obtain them for offenders. Some

argue that rehabilitation has never been tried in this country because we have never dedicated the resources required to do it.

Until the mid-1970s, rehabilitation was the dominant goal of American corrections. Indeterminate sentencing structures, with their emphasis on "corrections" centers and institutions, and reliance on parole boards to determine when an individual was "ready" to be released (that is, cured) were at least partially based on a rehabilitative model of sentencing.

## Incapacitation

The emphasis in an incapacitative approach is on preventing reoffending by restricting or disabling the offender, that is, by acting to reduce or eliminate the offender's opportunity to commit more crime. There are different degrees of incapacitation. Extreme examples, such as the death sentence, are not uncommon. In some societies the hands of thieves are cut off, and, in our own country, judges have ordered both physical and chemical castration of sex offenders.

Mandatory life prison sentences are required in some States for so-called habitual criminals. Other forms of incapacitation emphasize restricting rather than disabling the offender. Curfews, house arrest, required attendance at day reporting centers, and even the requirement of continuous employment or participation in work crews can be used to incapacitate offenders -- that is, to reduce their opportunity to commit crime.

## Deterrence

### *General Deterrence*

General deterrence is the principle that underlies the notion of "making an example" of someone or of "sending a message" to particular audiences by the way in which someone they might identify with is treated. The idea is to frighten *the population of potential offenders* into remaining law abiding. To prevent crime, general deterrence uses the fear of getting caught (publishing the names of drunk drivers or prostitution customers in the local paper), the probability of getting caught (random tax audits), or the unpleasant consequences of conviction (the sanction itself).

### *Specific Deterrence*

Specific deterrence uses the same fears (of getting caught and the consequences of getting caught) to induce law-abiding behavior in *an individual*. It is believed that the consequences of the original act will so scare an offender that he or she will not reoffend.

A common example of an attempt to achieve specific deterrence is sentencing to a shock probation program. Typically, a judge will sentence an offender to some period of incarceration, let him or her serve a short portion of it (known as "a taste of the bars"), and then suspend the remainder of the sentence.

In misdemeanor courts, where judges have fewer options at sentencing, specific deterrence is a fairly common sanctioning purpose. "A few days in jail" is a typical sentence designed to scare a first-time or frivolous offender (whose crime resulted from a prank or dare) or to discourage a prostitute.

As with other utilitarian purposes, specific deterrence is based on a particular understanding of human behavior: that future behavior is affected positively by the unpleasant consequences of past behavior.

### **Restoration**

Unlike the other purposes of sentencing, which have a long history of debate and definition, restoration has no commonly accepted single definition. Relatively little has been written about it, and the understanding of its meaning in practice is still fluid. Its treatment here is necessarily tentative.

Restoration -- sometimes referred to as reparation -- aims to restore the community to its state before the crime was committed. As in retribution, the crime is viewed as a disruption of the peace or a tear in the moral fabric of the community, but the aim of restoration is to repair the peace rather than punish the offender.

There are many aspects to restoring the community. To the extent possible, restoration is used to provide reparation to the victim for the damage done, including the payment of financial restitution. It also focuses attention on the conditions in the community that may have contributed to the commission of crime in the first place. The aim of restoration is securing the safety of the community by preventing the offender, through rehabilitation, incapacitation, or deterrence, from reoffending. It offers the offender the opportunity to restore himself or herself to peace with the community by allowing him or her to make reparation for the offense.

#### **Goals and Purposes of the Justice System**

- Retribution or punishment
- Rehabilitation
- Incapacitation
- General and specific deterrence
- Restoration

### **The Values of the Criminal Justice System**

The system of criminal laws and criminal justice in this country confers an enormous amount of power on its decisionmakers: to intervene in the lives of citizens; to constrain or restrict their freedom of movement, freedom of association, and freedom of speech; to order their submission to treatment, payment of fines and fees, attendance at work, or urination on demand; and to permit the unlimited and unannounced inspection of their homes and workplaces. In directing

and conducting the operation of the system, criminal justice policymakers are guided by rules and values that define the limits of that power in practice.

Some of the common values that guide policymakers and decisionmakers are described below.

### **Proportionality**

Proportionality is the principle that a sanction should not be any more onerous, intrusive, or painful than warranted by the severity of the crime. This is a critical limiting principle in the imposition of sanctions whose ostensible purpose is to do good, where the temptation to do A LOT OF GOOD is hard to resist. It is one of the fundamental principles of sentencing legislation and decisions.

### **Equity**

Equity is the principle that similarly situated offenders are to be treated similarly. It specifically restrains the system from responding to or sanctioning a subgroup of the offender population for a reason or in a way that is unrelated to their criminality.

Two examples of this principle are currently under discussion around the country. The first involves the passage in some States of laws that sentence offenders for possession or distribution of various amounts of crack cocaine more harshly than offenders who possess or distribute comparable amounts (in terms of use) of cocaine powder. One State supreme court rejected such laws as fundamentally flawed because the result was to punish one group of drug offenders very differently from another when the drug in question was the same except for its form.

The second example concerns the use of particular probation conditions for women offenders in response to perceived gender-related needs (parenting classes, life skills management, grooming classes), rather than to the behavior associated with their criminality (drug treatment, job training, and so forth). A female offender should be sanctioned in a way that is appropriate to the crime she committed and not in response to the fact that she is a woman.

### **Parsimony**

Parsimony is the commitment to using the least intrusive and least drastic measures and the smallest amount of resources to obtain the desired objective in sentencing. Resources might be measured as the time of a probation officer, the duration of confinement, or the cost of treatment.

As with proportionality, parsimony is an important limiting principle in the design of intermediate sanctions: In using intermediate sanctions, decisionmakers often believe that if a little is good, a lot is better. Unfortunately, in addition to wasting resources, the use of too many conditions, restrictions, and expectations with offenders in the community can create failure where success was intended.

## **Humane Treatment**

A commitment to humane treatment means that in deciding how and under what conditions sanctions are organized and carried out, the preference will be to seek the most humane method to achieve the goals of the sentence or the outcomes of the program. To choose the most humane way is to avoid unnecessary or gratuitous humiliation, pain, and discomfort.

<b>Values of the Justice System</b>
<ul style="list-style-type: none"><li>• Proportionality</li><li>• Equity</li><li>• Parsimony</li><li>• Humane treatment</li></ul>

## **System Goals**

In addition to their overarching concerns relating to crime prevention and public safety, criminal justice decisionmakers are concerned with how well the system functions in its use of public funds and maintenance of the public trust. In making decisions, they are seeking to achieve goals in this area as well.

The system goals that come into play in the use of intermediate sanctions include the following:

**Use resources efficiently and effectively.** Making the best use of public monies is an obligation of everyone who serves in the public sector. That obligation has grown even more pressing in recent years as the demands for public services continue to outpace revenue. In the correctional system, it requires that sanctions be tailored as carefully as possible to ensure that they provide only the supervision or services necessary to achieve their intended goal(s).

**Reduce crowding in jails and prisons and probation caseloads.** Whatever its goals, a correctional program can hope to achieve them only if it has the appropriate balance between the demand for services and the resources to meet that demand. The balance of resources and demand has been lost in most jurisdictions in recent years. State and local legislatures have approved new funds for institutional construction and system operating costs, but they have also continued to make policy decisions that escalate the demand for space. The needed space may be in a jail, in a prison, or on the caseload of a probation or parole agency.

**Process cases in a timely manner.** The swift resolution of cases pending against individuals is a hallmark of a good justice system. Court delay has become a major problem in many courts around the country. Not only does delay affect the quality of justice, but it also can act as an albatross, impairing the court's ability to move forward on other issues or initiatives.

**Enhance the credibility of criminal justice agencies and institutions.** For a wide variety of reasons, the public has lost confidence in the ability of the courts, corrections, and other criminal

justice agencies to deliver on their promises regarding public safety. Part of the problem may be in the promises themselves; nonetheless, agencies have much to do to restore public confidence.

**Produce resources that offset costs.** As part of an effort to both conserve public funds and renew public confidence, many criminal justice agencies are looking for ways to generate resources. They may do this through improved fine collection, community work service by offenders, the payment of restitution to victims, or fees paid for probation supervision.

## The Steps in the Adjudication, Sentencing, And Discharge Process

The process by which an accused offender moves from arrest to full discharge of his or her sentence has many decision points, each with many variations from jurisdiction to jurisdiction, and each with many decisionmakers and possible decision outcomes. Within this process, at several points a judge or paroling authority can order a defendant (preadjudication) or offender (postadjudication) to get treatment. Not all of these are sanctions. *Sanctions*, and therefore intermediate sanctions, apply only to those steps that follow adjudication, that is, a finding or plea of guilty. For purposes of clarity, several of both kinds of steps are reviewed here. The first two describe preadjudication steps in the process; the resulting conditions are therefore conditions, not sanctions. The remaining steps follow conviction, and the orders that result are sanctions.

### Pretrial Supervision in Lieu Of Detention

Following arrest, a defendant is typically brought before a judge, bail commissioner, or magistrate for a decision on the conditions under which the defendant will await trial. A defendant can be released on his or her own recognizance (also called R.O.R, that is, a sworn promise to return), can be detained pending the posting of a certain amount of bail, can be detained with no bail (very unusual), or can be released under certain conditions, such as keeping a curfew or reporting periodically to a supervision officer. An increasingly common condition of release is participation in some form of treatment. Compliance is monitored by a pretrial supervision agency or the probation department. Should the individual fail to comply with the conditions of release, he or she can be returned to jail for detention prior to trial. Successful completion of the treatment or other conditions may mitigate the sentence that may result upon conviction.

### Pretrial Diversion: Treatment in Lieu Of Prosecution

Treatment as part of pretrial diversion differs from treatment as a pretrial condition of release in several important ways. The decision to order treatment as part of pretrial diversion typically (though not always) rests with the district attorney's office. The prosecutor offers to cease all prosecution of the case if the defendant completes the prescribed treatment regimen. However, if the defendant fails to complete the treatment and satisfy the other conditions of diversion, he or she may risk being sentenced more harshly (if prosecution proceeds and a conviction results) than if the individual had never entered the diversion program.

Since pretrial diversion occurs before individuals have pled guilty or been convicted by a judge or jury, these individuals are technically innocent. Because of their anxiety about the outcome of pending charges, those charged may be more motivated at this time to agree to cooperate with treatment. Many treatment providers view this as an ideal time to intervene by offering an opportunity to participate in treatment.

*(Note: A forthcoming Treatment Improvement Protocol will examine the use of AOD abuse treatment within the context of alternative case processing. Many jurisdictions have expanded this option through so-called drug courts.)*

## **Sentencing**

Following adjudication and a plea or finding of guilt, the offender is subject to sentencing by the court. Intermediate sanctions are most often ordered at this time. The sentence itself takes many legal forms, depending on the jurisdiction. The sentence may be to a term of probation in lieu of a term of imprisonment; the intermediate sanctions, including any AOD abuse treatment, are imposed as *conditions of probation*. In other cases, the intermediate sanctions are themselves the terms of the sentence. In some States, the actual judgment and conviction are suspended pending successful completion of the terms imposed by the court, including the intermediate sanctions.

Regardless of the specific legal form under which the sanctions are ordered, the court retains the right to revoke the offender's probation if the terms of the original sentence are violated and to impose a term of incarceration or any other sanction it may choose.

Although the sentence is imposed by a judge, the decision is influenced by other parties, including the prosecutor, defense attorney, and the probation agent, as well as by the traditional practices of the court.

The most important influence on sentencing decisions in individual cases is the prosecutor's power to choose the charge upon which conviction will be sought. Since any single act can be charged under many different crime statutes, some of which may carry restricted sentences, this discretion is considerable. When the prosecution and defense attorney discuss plea agreements, the prosecutor brings this ability to negotiate the charge to the table. Because more than 90 percent of felony convictions in the State courts are the result of guilty pleas rather than trials (Bureau of Justice Assistance, U.S. Department of Justice, 1991.), these negotiations between the defense and the prosecution are the key grounds where sentencing is decided.

Defense attorneys provide mitigating factors and negotiate around weaknesses they perceive in the case. Some public defender offices are energetic at getting out into the community and identifying alternative sanctions that the court and probation office may not know about. Others are not. In either case, defenders typically advocate for the least restrictive sentencing, which may not always agree with treatment goals. In some defender offices, social workers interview clients to evaluate them from a clinical perspective.

Probation officers also influence decisions regarding intermediate sanctions, particularly in cases where presentence investigations are requested. In sentencing hearings (held when guilt has been

established at a trial, or following a guilty plea not resulting from a sentence agreement between the prosecutor and the defense), the prosecutor is expected to represent the people; the defense attorney represents the accused. The prosecutor urges tough sentences; the defense urges the least restrictive. A good probation officer examines the situation independently of the positions taken by the prosecutor and the defense. She or he will seek the most appropriate sentence based on a number of factors, including the offender's criminal history, employment history, family situation, physical and emotional problems, and other needs. The probation officer may, figuratively speaking, sit with the prosecutor in one case and with the defense attorney in another. The court may be inclined to give great weight to the probation officer's recommendations, trusting his or her independent judgment.

### **Probation Supervision**

In some jurisdictions, the court orders the offender to a term of probation and permits the probation agency to impose the specific level of supervision and additional conditions that may constitute intermediate sanctions. In this case, the agency retains the ability to order treatment, impose restrictions, or otherwise control the offender.

If the offender fails to observe or complete these conditions, his or her probation can be revoked by the court, and he or she is subjected to any sanction the court chooses. (See next step.)

In determining the level of supervision that individual offenders require, many probation (and parole) agencies employ classification systems. These systems use objectively derived instruments that measure offender risk as calculated by identifying the presence or absence of preidentified risk factors. The scores are used as the basis for grouping offenders into one of several categories for purposes of supervision.

### **Probation Violation: Treatment in Lieu of Revocation**

In the case of any offender on probation, the court may order intermediate sanctions, including AOD treatment, when the offender has been found to be in violation of the original conditions of probation.

Probation officers exert their greatest influence in probation violation and revocation cases. Although agency policy and practice also play key roles, individual officers typically have considerable discretion in handling violation behavior. (Violation behavior might include failure to keep a scheduled appointment, positive results of a urinalysis, or drinking in a bar when that was specifically forbidden by the probation conditions.) Probation officers can issue warnings, intensify supervision, bring the probationer in to be reprimanded by a supervisor, or bring the case back before the court and ask for a revocation. Officers may also bring a case to the judge and recommend an intermediate sanction instead of a revocation to jail or prison.

### **Condition of Release on Parole**

Parole is a form of supervised release into the community *following a term of incarceration*. In most States, a parole board decides on a case-by-case basis which inmates to release from prison,

when (at what point in the total sentence), and with what conditions. (If an offender is never granted parole and serves his or her entire sentence, he or she is said to "max out," and does not receive supervision after release.) In the same way that a judge orders conditions of probation, the parole board orders conditions of parole. Failure to comply with the conditions can result in a motion to the board to revoke parole and return the parolee to prison. AOD abuse treatment and some of the other intermediate sanctions described earlier are common conditions of parole release.

Not all States have parole as part of their sentencing laws. In such States as California, Washington, and Minnesota, an offender serves the term specified by the judge at the time of sentencing, minus any time off that term for good behavior or program credits, if those are available in the State. In that case, the offender leaves prison under *mandatory release* and usually has no conditions on that release.

### Parole Violation: Treatment in Lieu Of Revocation

As with probation, a parole board can impose intermediate sanctions, including AOD abuse treatment, in response to violations of the original conditions of parole and in lieu of revocation to prison.

Parole agents have the same power with parolees as probation officers do with offenders on probation. They can bring cases of parole violation behavior to the parole board for revocation or recommend an intermediate sanction. When a new crime has been committed, the offender is accountable to the parole board in addition to the court.

### Steps in the Adjudication, Sentencing, And Discharge Process

- Pretrial supervision in lieu of detention
- Pretrial diversion: treatment in lieu of prosecution
- Sentencing
- Probation supervision
- Probation violation: treatment in lieu of revocation
- Condition of release on parole
- Parole violation: treatment in lieu of revocation

## Understanding Intermediate Sanctions

### Sanctions vs. Programs

As indicated earlier, a sanction is a legally binding order of a court or paroling authority. A sanction may include a program or several programs, but these are not themselves the sanction.

Programs are organized activities and interventions designed to achieve specific purposes in many different arenas. They are typically created to address a specific problem or need; the strategies that they adopt to respond to or ameliorate the problem or need govern the

organization, activities, staff, and internal operating policies of the program. This TIP examines use of a variety of types of AOD abuse treatment programs for offenders offered within the jurisdiction of the criminal justice system as well as by community AOD abuse treatment programs that also serve nonoffenders.

Many treatment programs in both the justice system and the community have made the necessary accommodations to provide services to offenders. In fact, the history of treatment is replete with examples of accommodation in scope and purpose to meet the changing needs of clients. Programs have adapted from treating heroin addiction to treating teenagers sniffing glue and abusing LSD and to treating addiction to crack cocaine. Flexible programs can adjust to deal with offenders, even if they have not previously treated this population.

Successful integration of AOD abuse treatment and intermediate sanctions depends on a continuing process of monitoring and evaluating the impact and effectiveness of selected programs. Results-oriented programming can ensure the timely identification of problems and changing needs and permit the necessary redesign or adjustment of program components.

### **Sanctions Are Not Diversion**

Because the terms *diversion* and *intermediate sanctions* are so often used together, it is important to distinguish between them.

Diversion may occur before conviction and sentencing, in which case the diversion is a pretrial diversion. (See discussion above.) Confusion occurs when intermediate sanctions, ordered at sentencing, are referred to as diversion, meaning diversion from prison or jail. In this latter instance, diversion refers to the placement of an offender in a specialized corrections program designed for offenders in lieu of sending them to prison. In that specific instance, it is appropriate to use the term *diversion* for that specific intermediate sanction. However, most commonly used intermediate sanctions cannot properly be referred to as diversionary because it is difficult to prove that the offenders who are sentenced to them would otherwise have gone to prison. Pretrial diversion diverts the accused from prosecution. Post-sentencing diversion (which seldom occurs) diverts the convicted from prison or jail.

---

*Most commonly used intermediate sanctions cannot properly be referred to as diversionary because it is difficult to prove that the offenders who are sentenced to them would otherwise have gone to prison.*

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Chapter 3 -- The AOD Abuse Treatment System**

The alcohol and other drug (AOD) abuse treatment system is just as complex and has as many nuances as the criminal justice system. Once its basic components are understood, it will be clear how different parts of the treatment system fit the needs of different individuals with specific AOD problems, within or outside of the justice system. The AOD abuse treatment field uses two terms interchangeably -- client and patient -- to refer to the individuals with the disorder.

It is important to understand that AOD abuse problems are the same wherever they occur: The disorder is the same among offenders in a correctional setting as among the law-abiding residents of any community in the country. Many offenders are farther along in the progression of the disease than persons who have not yet resorted to crime to financially support their addiction.

Alcohol and drug use disorder, or addiction, is a progressive disease, with increasing severity of biological, psychological, and social problems over time. If left untreated, the disease can be fatal. It is called a biopsychosocial disease because the client experiences problems in the biological, psychological, and social areas of life. Substance use disorder cannot be cured, but it can be arrested, and individuals can make the behavioral changes necessary to recover and stay in recovery. Relapse is a common feature of the disease, and it is not unusual for an individual to relapse following treatment and to alternate between treatment and relapse until lasting recovery is attained.

The progression of the severity of the disease can be depicted on a continuum that ranges from experimentation on one end to recovery or death on the other. So, too, the components of treatment comprise a continuum, starting with prevention at one end and progressing to intensive inpatient programs at the other. An important principle to treatment providers is to intervene at the earliest possible stage with the least restrictive form of appropriate treatment.

The normal practice in treatment is to provide the least restrictive form of treatment that can be expected to work with any particular client, depending on how far the client has progressed on the continuum from experimentation to use, abuse, severe illness, complete inability to function, and finally, overcoming denial or dying. This last stage has been viewed either as "bottoming out" -- in other words, being able to get no worse and "giving in" to the need for treatment -- or death. In recent years, as experience in providing treatment has accumulated, treatment providers have become able to successfully help abusers to have a "high bottom" -- that is, to recognize

and overcome their denial and become motivated to do well in treatment at earlier stages in the disease's progression.

Several studies have suggested that mandated treatment is very effective. Intervention occurs earlier than it might have otherwise and the offender stays in treatment longer on average than the noncoerced client. Both early interventions and extended length of stay can contribute to better treatment outcomes. (See citations in the endnotes and bibliography.)

## The Goals of Treatment

The goals of treatment are to: 1) reduce incidence and prevalence of the chronic, progressive disease of addiction to alcohol and other drugs; 2) provide a system of services to assist people, their families, and communities in recovery from addiction, and 3) decrease the number of people who are at risk of becoming addicted. Treatment program personnel strive to support individuals, their families and significant others, and communities in the quest for recovery and healthful living. Services provided range from prevention and education through all stages of treatment, and include continuing care after the completion of treatment to prevent relapse, which is a prominent feature of the disease.

Secondary prevention and early intervention are part of the treatment continuum. Many people in need of treatment, for example, are at early stages in their disease, and one objective of their treatment is to prevent them from continuing to more advanced stages in the use of alcohol and other drugs. People at all stages of the disease can learn how to prevent its further progression.

### Goals of AOD Abuse Treatment

- Reduce incidence and prevalence of addiction
- Provide a system of services to assist recovery from addiction
- Decrease the number of people at risk of becoming addicted

## The History of AOD Treatment

AOD treatment experienced changes during the 1960s and 1970s that had an impact on both the substance abuse treatment and criminal justice fields. Addictions treatment traditionally was provided by mental health professionals and focused on addictive behavior as a symptom of an underlying mental or emotional illness. Treatment was often received in psychiatric hospitals, with limited followup after discharge. Support for self-help or support groups, such as Alcoholics Anonymous (AA), was limited among treatment professionals. Individuals dealing with AOD-related problems often found their own way to AA or other groups only after repeated failures in treatment. For these individuals, treatment failures were further compounded by such issues as marital, employment, social, and legal problems related to their addiction.

Perhaps because of the limited number of treatment successes and the lack of recognition of the role of other related problems, professionals cited clients' lack of motivation as the most frequent

reason for treatment failure. Because of this, treatment programs began to focus mostly on highly motivated voluntary clients. Motivation and voluntary enrollment became widely accepted as essential components for treatment success.

During the 1960s and 1970s, the emerging AOD treatment field began to develop different treatment approaches that focused beyond addictive diseases as disorders separate from mental illness. This view of addictions as separate diseases resulted in identification of specific treatments, which include long-term support and followup after treatment as essential components of treatment success. Therapeutic communities (TCs) were established, and professionals recognized community self-help groups such as AA.

TCs were viewed as alternatives to incarceration for offenders with AOD problems. TCs were among the first programs to treat drug-involved offenders who were either enrolled as involuntary clients or were given a choice between the TC or long-term incarceration. The long-term (1- to 2-year) treatment that TCs offered was designed to resocialize the individual who had developed a lifestyle of criminal behavior and addiction.

Shorter term residential treatment programs were also developed during this time, and many incorporated the 12 step model of AA. These programs were usually 30 to 60 days in length and emphasized learning how to live and maintain an alcohol- and drug-free lifestyle. A peer support philosophy was adopted and clients were encouraged to participate in AA during and after treatment. Followup treatment was offered to clients as needed and continued participation in AA was strongly encouraged to maintain sobriety and prevent relapse. Both TCs and short-term residential treatment programs continue to be viable options for treatment of AOD offenders.

The Federal Government gave new importance to addiction services through the creation in 1974 of the National Institute of Alcohol Abuse and Alcoholism (NIAAA) and the National Institute of Drug Abuse (NIDA), and emphasized the need for publicly supported addiction services. Resources were made available to States and community-based programs for the planning and implementation of prevention, intervention, and treatment services. These initiatives stimulated further expansion of treatment services and research into the nature of addictions.

The establishment of the Federal Law Enforcement Assistance Administration (LEAA) made resources available specifically for community-based treatment of AOD-involved offenders. One of the most successful models developed by LEAA was the Treatment Alternatives to Street Crime (TASC) program. Local TASC programs, administered by government agencies and private entities, provide screening, assessment, referral, and case management services to offenders, criminal justice systems, and AOD treatment systems. They provide the offender with support and accountability, monitor progress in AOD treatment, and make reports to the criminal justice system on compliance with sanctions.

These and other case management programs vary widely in the completeness of their screening and assessment and the breadth of their case management services. Most publicly funded treatment programs now offer counseling and testing for HIV infection, TB, and sexually transmitted diseases either onsite or by arrangement with a public health counseling and testing site. This is an essential component that must be provided by the criminal justice agency, the

case management agency, or the treatment agency. Specific agreements are needed to ensure that communicable disease testing is completed.

Case management services can be provided by any of the agencies involved as well, but should be comprehensive. That is, the services must focus not only on participation in AOD treatment, but also on other services such as teaching literacy skills or providing job training or medical care. The substance-abusing offender is almost always an individual with many problems who requires multiple services.

Case management approaches have, however, demonstrated that AOD-dependent individuals who are involuntarily involved in treatment through the criminal justice system can be rehabilitated. Substance-abusing offenders who are provided case management services have longer treatment retention and completion rates, greater accountability, and lower recidivism rates than offenders not involved in similar case management and intensive supervision programs.

## Levels and Types of Treatment<sup>1</sup>

Three major categories of treatment comprise the continuum: pretreatment services, outpatient treatment, and inpatient treatment (including residential care). Each category contains several subsets described as follows.

### Pretreatment Services

These services, which are not part of primary treatment, include primary prevention and early intervention.

Levels of AOD Abuse Treatment
<ul style="list-style-type: none"><li>• Pretreatment services</li><li>• Outpatient treatment</li><li>• Inpatient treatment</li></ul>

**Primary prevention.** These are services for persons who have not yet used AODs. Most primary prevention programs are in schools or the community, but some have been placed in correctional systems.

**Early intervention.** This may be a psychoeducational approach for people who have used AODs and are considered to be at high risk for AOD-related problems or have a history of AOD use, or it may be a screening process used to identify early AOD use problems. It is also appropriate for AOD-using persons who do not meet the diagnosis of an AOD use disorder. This approach may be used for ongoing evaluation for possible referral to a more intensive level of care. In some instances, early intervention can be used as short-term treatment for those whose AOD problem is of low severity.

## **Outpatient Treatment**

Also referred to as ambulatory care, outpatient treatment provides a broad range of services without overnight accommodation. Some of these services may be provided following inpatient or residential treatment or may be recommended after such treatment for continuing care.

**Nonintensive outpatient treatment.** This is AOD-focused treatment that includes professionally directed evaluation and treatment typically of less than 9 hours per week in regularly scheduled sessions. Nonintensive outpatient treatment may also address related psychiatric, emotional, and social issues.<sup>2</sup>

**Intensive outpatient treatment.** This is AOD-focused, professionally directed evaluation and treatment of 9-20 hours per week in a structured program. These programs may be evening programs, and frequently include some weekend programming.

**Methadone maintenance treatment.** This is a medically supervised outpatient treatment which provides counseling while maintaining the client on the drug methadone. This regimen is used primarily for heroin or other opiate addiction and provides a legitimate, closely monitored substitute for illegal or other prescription drugs. The client must be able to document at least a 2-year history of addiction to qualify for a methadone maintenance program.

**Day treatment or partial hospitalization.** This is AOD-focused, professionally directed evaluation and treatment of more than 20 hours per week in a structured program. This is the most intensive of the outpatient treatment options and can be used for treating patients who demonstrate the greatest degree of dysfunction but do not require inpatient or residential treatment. Evening and weekend programming may be included.

## **Inpatient Treatment Options and Residential Care**

Inpatient treatment options include intensive medical, psychiatric, and psychosocial treatment provided on a 24-hour basis. The continuum of residential care includes psychosocial care at the most intensive end and group living with no professional supervision at the least intensive end.

**Medically monitored intensive inpatient treatment.**<sup>3</sup> This level of care involves around-the-clock medical monitoring, evaluation, and treatment in an inpatient setting. It is used for patients who have acute and severe AOD use disorders and who may also have a coexisting medical or psychiatric problem. Such treatment generally involves a short-to-intermediate length of stay (7 to 45 days) and may include nonmedical or social model programs with variable lengths of stay.

**Medically managed intensive inpatient treatment.**<sup>3</sup> This level of care involves around-the-clock, medically directed evaluation and treatment in an acute-care inpatient setting. This level of care is appropriate for the treatment of medical and psychiatric problems that may require biomedical treatment (such as life support) or secure services (such as locked units). Such treatment generally involves a short-to-intermediate length of stay (7 to 45 days).

**Short-term nonhospital intensive residential treatment.** This treatment is generally 21 to 45 days in length and is designed to teach the client how to live an AOD-free life and to provide motivation for the maintenance of such a lifestyle. Followup care on an outpatient basis and continued participation in peer support groups is recommended to maintain the recovery process begun in the residential setting.

**Intensive residential treatment.** This long-term (6 to 24 months) treatment model may be directed by an AOD treatment professional or may be medically directed. The model is similar to the therapeutic community model. It is appropriate for persons with multiple problems, especially those with dual disorders involving a personality and an AOD use disorder. The goal of psychosocial rehabilitation is always part of treatment.

**Psychosocial residential care.** This is a long-term (6 to 24 months), professionally directed, psychosocial care model. The model is also similar to the therapeutic community model and relies heavily on peer pressure as well as formal treatment to shape behavior. It is appropriate for persons with AOD abuse problems and concomitant disorders that do not require acute medical or psychiatric intervention. Persons compliant with psychiatric and other prescription medications may be appropriate for this level of care. The focus of care is on psychosocial rehabilitation.

**Therapeutic community.** The traditional therapeutic community is a long-term (15 to 24 months) rehabilitative model that relies primarily on peer staff (usually those who have been rehabilitated by the program) and on work as education and therapy. Other staff include treatment and mental health professionals and vocational and educational counselors. Because the aim of the therapeutic community is a global change in a person's lifestyle focused on the development of vocational, educational, and social skills, it is appropriate for persons with AOD abuse problems and chronic deficits in those areas. Most residents have been involved with the criminal justice system.

**Halfway house.** A halfway house is a residential, transitional living arrangement with minimal treatment in which residents are supervised by paid staff. Residents may work and receive education, training, or treatment in the surrounding community, although some treatment may be provided in the house. House responsibilities are shared, and rules must be followed. The length of stay may be limited or unlimited, contingent on the attainment of specific progress goals.

**Group home living.** This refers to a residential, transitional living situation without any specific treatment plan and minimal staff supervision. It is sometimes known as a three-quarter-way house. Residents may work and may receive education, training, or treatment in the community. House residents generally decide on admission of new residents. House responsibilities are shared, and the house is governed and run by its residents. The length of stay is generally unlimited as long as abstinence from AOD is maintained. The Oxford House model includes complete resident self-governance and self-sufficiency. The key to success in all such models is that the living situation is AOD-free and thus supports resident abstinence.

## Treatment Components

Programs vary depending on the individual needs of the client population and the availability of resources. Despite these variations, certain services are basic components of treatment for AOD-abusing persons. Sometimes a lack of resources imposes limits on services such as reducing length of stay, frequency of client contacts, and the availability of specialized skills and services. Programs that cannot provide all necessary components for alcohol and other drug treatment within their own facilities often establish ongoing linkages with other resources in the community that can provide them.

Preliminary screening and assessment should occur before the client enters any treatment program. The screening and assessment process is very important, and may be confused by members of the justice community with the classification process conducted by the agencies and institutions of the justice system. The purpose is the same: to determine the most appropriate response (whether clinical or correctional) to this individual. In addition, many probation and parole agencies use a "needs assessment" process that may look at similar client information. The analysis and the results of classification are very different, however.

In AOD abuse assessment, trained professionals or paraprofessionals collect information from the prospective client to determine whether the individual needs treatment and, if so, what level of treatment. Various types of screening and assessment instruments are available for this purpose. Following the assessment, in an ideal situation, the client will be placed in a treatment program that can best meet his or her needs.

This chapter lists and discusses components of treatment, many of which are *core treatment components* of an effective and comprehensive program. Detoxification, which is a necessity for many patients, is often provided in a hospital under a physician's supervision prior to admission to a treatment program. In some cases, detoxification may be provided in a treatment program which is based in a or has access to a medical facility. Following an initial discussion of detoxification, components that are essential to the largest number of programs are described, followed by those that may be less essential. The extent to which a treatment component is essential will vary depending on the program. The components discussed below are:

- Detoxification
- Intake
- Screening
- Assessment
- Treatment planning
- Group therapy
- Family therapy
- Individual therapy
- Case management
- Drug testing
- Education sessions
- Emergency services
- Recreational activities and peer socialization

- Other specialized groups
- Relapse prevention and continuing care programs
- Multifamily groups
- Psychiatric interventions and dual diagnosis services
- Self-help groups
- Intervention
- Educational services (applicable to partial hospitalization and other programs which preclude attendance in school) and vocational training.

## **Detoxification**

Clients requiring detoxification may be treated in inpatient, residential, or outpatient settings. A client's particular psychosocial circumstances, personal characteristics, or addictions may mandate inpatient care. The process begins with an assessment of the client's need for detoxification and a determination of the most appropriate site for the provision of such treatment. Whether it is conducted on an outpatient, residential, or inpatient basis, detoxification should be monitored by appropriately trained personnel under the direction of a physician who understands the possible consequences of detoxification and has specific expertise in the management of withdrawal and abstinence.

## **Intake**

Intake counselors and other staff require training to ensure that treatment begins with the client's initial contact with the program. This first step in the treatment process should be to put the new client at ease and provide a brief overview of the program's parameters, such as length of treatment, treatment expectations, and program philosophy.

## **Screening**

The screening process begins at intake and extends through the conclusion of the assessment process. Screening often entails a brief interview and the administration of a standardized, validated screening questionnaire to identify the appropriate treatment level. It is at this point that the client and the evaluator answer the following questions: "What services are needed?" and "What program is the best match for the client?"

It is best if the screening process and initial decisions regarding the most appropriate treatment setting are made by an individual or agency that has no financial stake in a particular placement, thereby avoiding a conflict of interest or the appearance of one.

It is essential that screening for communicable diseases (HIV, TB, and sexually transmitted diseases) be an integral part of the initial screening and assessment process. This counseling and testing may be done on site by the criminal justice agency, an intermediate case management agency, or the AOD treatment agency. It may also be done by agreement at a public health counseling and testing site. Formal agreements are necessary to ensure that screening for communicable diseases is offered to all AOD-abusing offenders.

## **Assessment**

The assessment process involves a more in-depth evaluation of the client, lasting one or more sessions, including confirmation of the client's treatment referral and an individual and family psychosocial assessment. This step in the treatment process will give the clinical staff an understanding of the needs of the client, his or her motivation for treatment, and what substance use and other mental disorders may be present. The assessment provides a basis for developing an initial treatment plan.

In conducting the assessment, information should be obtained from multiple sources (such as the client, family members, significant others, counselors, probation officers, peers, and the client's employer), with the aid of multiple methods (such as self-administered questionnaires, interviews, and urinalysis). A comprehensive evaluation should address the following content areas: AOD use and treatment history, signs and symptoms of AOD abuse, intra- and interpersonal factors, environmental factors, medical and mental health status, educational status, employment status, and legal status.

The program's confidentiality regulations should be explained. The client will then be asked to sign a release of information and a form indicating consent to receive treatment. The program's grievance policies should also be explained, as well as how abstinence is monitored (for example, by urinalysis). Finally, the program's guidelines should be explained, as described below.

## **Treatment Planning**

### ***Client Guidelines***

Each client should receive a written set of program rules that represent the expectations of the treatment program. These rules may be presented in the form of a written contract that is signed by the client. The guidelines should include: 1) the requirement of abstinence during treatment, 2) rules for client behavior (such as respecting others and not being violent), and 3) the consequences of breaking rules. This process helps clients establish boundaries and understand that they are accountable for their behavior. Program staff are expected to abide by the same rules and code of behavior.

---

*Each client should receive a written set of program rules that represent the expectations of the treatment program. These rules may be presented in the form of a written contract that is signed by the client.*

---

### ***Client Involvement***

Early in treatment, clients should also be encouraged to outline their expectations of the program, defining what they expect to get from treatment. These goals can be incorporated into the

treatment plan. The client's participation in the development of the treatment plan is very important to success and retention in treatment.

Other kinds of client expectations may be encouraged. For example, a program may support tobacco cessation among participants, but may choose not to mandate an absolute no-smoking policy for the individual in the first days of treatment.

### ***Family Guidelines***

Family members should be actively involved in all aspects of treatment whenever possible (including criminal justice system treatment programs), and need to be aware of expectations with regard to behavior and attitudes. Program staff should work collaboratively with the family and involved helpers. Family guidelines are one way to reinforce a family-centered treatment approach.

### ***Group Therapy***

Group therapy involves peers in a group process that encourages them to address personal issues and the consequences of their AOD involvement. Unlike self-help groups, therapy groups are led by counselors. Group therapy is designed to solicit the involvement and support of others and to encourage healthy interaction. Through sharing, discussion, and problem solving, clients can begin to recognize denial and other signs of minimization and take responsibility for their AOD problems.

### ***Family Therapy***

Families benefit from individual sessions, with and without the client present. Substance abuse often reflects family dysfunction and family tolerance of AOD use. For the client living with or dependent upon the family, recovery is difficult without the active involvement and support of the family. Family sessions address how the family must change its patterns of behavior and communication, values, and problem-solving strategies.

### ***Individual Therapy***

Clients may need to receive individual therapy in addition to group and family therapy. Some clients are too withdrawn and socially uncomfortable to benefit from the group process, and they require individual therapy. Individual therapy helps clients: 1) cope with obstacles to utilizing group and family therapy and self-help groups, 2) discuss specific issues that they may not be ready to discuss in a group context, 3) improve the treatment alliance, and 4) help correct interpersonal difficulties and weaknesses.

### ***Case Management***

Case management is a term used by both the criminal justice and AOD treatment systems because both systems have recognized the great need for coordinated services. For clarity, it would probably help to refer to "AOD case management" and "justice system case

management," and, perhaps, "combined case management." The term, case plan, is used only by the justice system. Treatment plan is an AOD term. (Case management is further discussed in succeeding chapters of this TIP.)

Case management provides linkages with other service providers or between systems (such as the criminal justice system and the treatment program) in an effort to assist the client with his or her special needs. It is conducted by a designated case manager, who is responsible for coordinating all aspects of the treatment plan. Case management involves collaboration and networking with other agencies in the community to fill the gaps in services not offered by the treatment program. The range of supplementary services may include domestic violence services, medical care, dental care, housing assistance, mental health treatment, help in preparing Federal and State assistance applications, and childcare, as well as legal, educational, and vocational services. Helping the client and family negotiate the various service systems and coordinating the referral process are vital aspects of case management.

Many clients and families have several psychiatric, psychological, social, economic, and medical problems that will complicate recovery. Coordination, treatment planning, and decisions about how to divide tasks among various agencies require the attention and skill of case managers. Their involvement can help families and clients become more functional and more organized.

In the case of offender-clients, interagency case management becomes especially critical. Such clients are usually in treatment because of a court order and are typically under the continuing supervision of agents of one or more correction agencies. (For example, the offender may already be on probation or parole for one crime and on pretrial release status for another.) Client behavior while in treatment, including completing the treatment program, has significant consequences for the client's future. Expectations of the agencies involved, such as reporting requirements and appropriate responses to program rule violations, must be clarified and confirmed in writing. (This topic will be covered in detail in succeeding chapters.)

---

*In the case of offender-clients, interagency case management becomes especially critical. Such clients are usually in treatment because of a court order and are typically under the continuing supervision of agents of one or more correction agencies.*

---

The coordination of case management among various service providers may take the form of interagency agreements, including ongoing group case management meetings with agency representatives. Treatment programs should not wait for these systems to initiate such collaboration, but should begin the process themselves. The development of a coordinated case management protocol can enhance treatment effectiveness by decreasing the possibility that:

- Clients will manipulate the various systems providing services,
- Clients will perceive that the system "doesn't care" (since key concerns may have been insufficiently addressed), and

- The various systems will implement strategies that result in conflicting, duplicate, or contraindicated services.

Case management meetings can be particularly important when the client has other diagnoses in addition to AOD abuse. For example, if a client is HIV positive and has AOD problems, meetings with the agencies that provide medical care and support services may be necessary. Similarly, if there is a dual diagnosis -- AOD abuse and a mental disorder -- coordination between the treatment program and a mental health program is usually required. Few treatment programs can offer the needed mental health services themselves.

In all contacts with other agencies and individuals, there must always be respect for the client's right to confidentiality. This is particularly pertinent to issues of substance abuse, sexuality, and health problems such as HIV. (See [Chapter 7](#) for a full discussion of the legal and ethical issues surrounding client confidentiality.)

### **Drug Testing**

Clients in treatment may minimize, deny, or otherwise distort the extent of their AOD use. To determine recent use, to be able to confront use during treatment, and to provide information about relapses, frequent urine drug screens may be helpful. Testing all clients at intake, random screening during treatment and continuing care, and designated screening when the therapist believes a client is deceptive about use are suggested. However, urinalysis screens measure only recent use, and do not provide information about the onset of substance abuse, the rate of use, or the quantity of use, except for recent levels. Periodic random testing may be required by the court or other legal authority for the offender-client.

### **Education Sessions**

Education sessions provide an opportunity for the client to learn about the effects of AOD abuse in a nonthreatening setting. Conducted like a classroom experience, these sessions often help people gain insight into their AOD problems and increase their motivation for self-care. They are also effective in decreasing denial and negative feelings about the treatment process.

The topics selected for education sessions will depend on the needs of the client population and the resource capabilities of the program. Referrals may be possible to other community programs for certain groups. Topics discussed in education groups can include the following:

- Medical effects and consequences of drug use and abuse
- The disease model of addiction (including the signs and symptoms)
- Introduction to 12-step programs (for example, step work, traditions, spirituality)
- Denial and other defense mechanisms
- Effects of substance abuse on the family, codependency, and issues of the children of alcoholics
- Thinking errors or illogical thinking patterns
- Human sexuality (When possible, there should be separate male and female groups. Issues pertaining to the problems experienced by gay men and lesbians may need special attention.)
- HIV/AIDS education
- Coping skills

- Communication skills.

## **Emergency Services**

Emergency service is an essential treatment component when working with AOD-abusing clients, some of whom may be suicidal or violent. Programs must make emergency services available by providing the on-call availability of medical and mental health professionals, crisis intervention, crisis management, and referrals to crisis and emergency shelter programs. It is not unusual for clients and families to experience great stress during the early phases of assessment and treatment. Crisis intervention can address these stresses and help the client and family (or significant others) make decisions that are likely to reduce the strain and permit the course of treatment to begin.

## **Recreational Activities and Peer Socialization**

It is important to explore alternative ways to have fun without the use of AODs. Mastering social situations and physical and mental challenges enhances clients' self-esteem and improves their repertoire of social and practical coping skills. Staff can participate in the activities, serving as positive role models for the clients. Many programs employ recreational therapists to coordinate these activities.

## **Other Specialized Groups**

Most persons in treatment have special life problems and individual needs. It is important for programs to be flexible, and to provide group treatment opportunities for them. The need for particular specialized groups will vary greatly depending on the nature of the client population. If a client has a particular need and a group is not available, it may be possible to address the issue in individual treatment or through referral services. Relevant topics for specialized groups are discussed below.

### ***Cultural Groups***

Programs must be responsive to the needs of clients from a variety of ethnic and cultural groups. Separate group meetings may be needed to address general as well as specific ethnic, racial, and cultural concerns. Specific issues might include:

- Racism
- Anger and frustration
- Cultural drug use patterns
- Discrimination
- Family patterns
- Rituals and ceremonies
- Negotiating service systems that may be insensitive to the needs of ethnic groups
- Positive aspects of "being different"
- Advocating for systemic change.

### ***Specialized Services for Women***

Many issues for substance-abusing women such as physical and sexual abuse cannot be adequately addressed in mixed-gender groups. These issues and others unique to substance-abusing women must be addressed in separate women's groups and in individual treatment. Pregnant women require counseling and courses concerning care of themselves and their unborn children, as well as prenatal care. (See the TIP *Pregnant Substance-Abusing Women*.)

### ***Social Skill Building, Problem Solving, and Conflict Resolution***

Social skill building and peer socialization take place in all groups as clients learn to talk about themselves and to listen to others. Prolonged AOD use often results in social skill deficits. Unless these deficits are overcome, clients will feel uncomfortable and out of place with peers who do not use AODs. Their primary area of personal reference will be drug knowledge and experience, making it difficult to maintain a clean and sober lifestyle.

Programs should encourage the development of new social skills or the enhancement of existing skills by presenting information, offering practice opportunities in group therapy, and incorporating naturally occurring social opportunities. Social skills to focus on might include: self-disclosure, giving and receiving positive and negative feedback, problem solving, conflict resolution and mediation, negotiation, assertiveness, coping with peer pressure, communication skills, understanding the cycle of violence, socializing and taking part in recreational activities without the use of alcohol and other drugs, and setting realistic personal goals. It is essential to offer conflict resolution groups when programs are in areas where there is a high rate of violence.

### ***Human Immunodeficiency Virus (HIV)***

As the HIV epidemic spreads among the AOD-abusing and offender populations, increasing numbers of clients will test positive for the HIV virus. Support groups for AOD abusers with HIV infection or full-blown AIDS are becoming a standard part of AOD abuse treatment programs. Other clients are dealing with concerns regarding significant others who have AIDS or who are HIV-infected and may need the support of a group.

### ***Tobacco Cessation***

Tobacco is an addictive substance that continues to be a significant public health problem. Specific behavioral and educational programs aimed at smoking cessation may be offered.

### ***Independent Living Skills***

Clients, especially those who will soon become independent, may require basic survival skills. Such skills include: money management, shopping, daily planning, job skills, finding an apartment, adjusting to roommates, developing supportive friendships and relationships, and using social support systems.

### ***Diagnosis-Specific Group***

Because of the high prevalence of psychiatric disorders among AOD-abusing clients, especially among offenders, these problems must be addressed as part of the treatment and relapse prevention conducted by specialized professionals. Ideally, clients sharing the same diagnosis should have access to their own group sessions. Funding, program priorities, and time limitations may prevent a program from providing this service, however. When these groups cannot be provided, it is incumbent on the program to utilize appropriate services in the community.

### ***Health, Sexuality, STDs, and Contraceptives***

To support the development of health promotion practices, programs should offer courses on special topics such as nutrition, STDs, contraceptives, and tuberculosis. These courses should be offered in addition to initial education concerning high-risk behaviors and initial counseling and testing.

### ***Alumni Groups***

Alumni groups are organized to exert positive peer pressure, to foster support and encouragement to stay in treatment for those who are struggling in early recovery, and to increase social opportunities and decrease isolation. These groups are especially helpful to outpatient programs, which, due to limitations on time and staffing, do not always have the same opportunity as residential programs to maintain consistent contacts with recovering clients.

### ***Groups for Drug Dealers***

Topics to be addressed in groups of drug dealers include: transferring short-term gratification to long-term goals (including vocational and educational objectives); recognizing that selling drugs involves entrepreneurial skills that can be redirected toward legal ventures; reinforcing alternatives to the hopelessness and despair that exist in some communities where the most visible role models are drug dealers; confronting the perception that society condones illegal drug activities and that dealers always "get away with it;" and learning techniques and skills to counteract pressure to continue dealing drugs.

### ***Prostitution-Specific Group***

Many programs have clients who engage in prostitution or "survival sex" to support their drug use. They may benefit from participation in a specialized support group. Prostitution, which may occur in males as well as females, is often intertwined with AOD use and is seen frequently among street persons who may be homeless.

### ***Drug-Specific Groups***

Patterns of drug abuse vary from community to community, year to year, and client to client. Certain substances, by their very nature, may require a specific focus. For instance, many communities are once again experiencing a problem with heroin abuse. Programs may wish to

offer a specialized group for persons who use specific drugs or who have specific drug use patterns.

### ***Gay and Lesbian Clients***

Gay and lesbian clients may struggle with a range of issues that require attention in a specialized group.

### ***Additional Specialized Groups***

Additional groups may be defined by a wide range of unique factors or client characteristics. Such defining characteristics might include age, sexual victimization, medication prescribed, steroid use, having an eating disorder, grieving, and being children of alcoholics or codependent.

### ***Discharge, Continuing Care, and Relapse Prevention***

At the completion of inpatient treatment, there should exist a structured and time-limited outpatient program and planning process that can assist the client in continuing recovery and obtaining ongoing support. This type of program is often referred to as a continuing care program (or aftercare). A smooth transition from inpatient treatment to discharge and then to continuing care requires coordination of goals and treatment, identification of personal signs of relapse, family involvement, and linkages to other services as necessary. The AOD abuse treatment program should be prepared to assist the client if relapse occurs. Relapse does *not* mean that treatment was a failure. Rather, it can be viewed as a bridge to the provision of new information and an opportunity for emotional and intellectual growth.

A body of knowledge is emerging that focuses on the problems of relapse. Programs need to be sensitive to the warning signs of relapse, strategies (such as stress management) to manage the prolonged abstinence syndrome, and strategies to prevent relapse. For instance, clients should be provided with opportunities to discuss the emotional, behavioral, and environmental stimuli that were associated with their drug use and to develop strategies to counteract these triggering factors. Two elements of relapse prevention are the preparation of a recovery plan, often called aftercare planning, and the client's continued program affiliation after he or she has completed primary treatment. Many continuing care programs have specialized groups for relapse prevention, while other specialized groups focus on making the transition from intensive treatment to a lower level of care.

### ***Multifamily Groups***

Like their AOD-abusing family members, families can benefit from group therapy with other families. In this setting, families learn that they are not alone in their present struggles; they are assisted in fostering expectations that treatment will work and are aided in developing solutions to problems. A series of planned presentations is often a component of multifamily group therapy.

## **Psychiatric Interventions and Services for Dually Diagnosed Individuals**

*Dual diagnosis or dual disorder* are new terms that refer to the coexistence of AOD abuse and psychiatric disorders. A complete assessment will help establish whether a client's disorder is primary to, secondary to, or independent of another existing disorder.

The decision about whether to treat the AOD abuse or the psychiatric disorder(s) first is a difficult one. The general rule is to immediately treat the disorder that is most acute in presentation, that most interferes with present function, that immediately threatens the client's life, or that has an organic origin and can be medically treated. Other circumstances must be considered when deciding whether two disorders, such as AOD abuse and major depression, can be treated concurrently. Treatment planning, consultation, and continued assessments can help address these decisions.

Coexisting psychiatric disorders can interfere with AOD abuse treatment, and if they are left untreated, the client is more vulnerable to relapse. AOD treatment staff should be able to identify coexisting psychiatric disorders and either treat them or provide appropriate referrals for treatment. A consultant may be hired to conduct mental health assessments, or the client may be referred to an outpatient mental health program for evaluation. It is important that staff be aware of the special problems of the person who is dually diagnosed with AOD abuse and a mental disorder. Gathering and sharing clinical data, formulating a diagnosis, and planning intervention for these clients with special needs should be conducted by a treatment team of AOD treatment staff and mental health personnel. Staff should also be aware that some severely ill, dually diagnosed patients tend to be fragile. Transitional confrontational AOD abuse treatment techniques are counterproductive with this group and may exacerbate the concomitant disorder.

Pharmacotherapy for AOD-abusing clients must be accompanied by close observation and monitoring of target symptoms.

### **Self-Help**

Self-help meetings that are appropriate for the age, gender, and culture of clients are frequently of therapeutic benefit. These meetings, which can be utilized during and following primary treatment, are valuable adjuncts to outpatient services for the client during the recovery process. Self-help groups offer positive role models, new friends who are learning to enjoy life free from AODs, people celebrating sober living, and a place to learn how to cope with the stresses and strains of life. A 12-step model is the most common structure of a self-help approach, but others, such as Rational Recovery and religious programs, may be appropriate.

### **Intervention**

In AOD abuse treatment, the term "intervention" refers to an effort by family, friends, or others, along with professionals, aimed at intervening in the progression of an individual's AOD abuse and encouraging her or him to enter treatment. The most commonly used intervention was developed by Vernon Johnson and popularized by the Johnson Institute ([Johnson, 1986](#)). The

intervention process focuses on convincing individuals that they have an AOD problem, helping them recognize the need for treatment and, eventually, changing their behavior.

Interventions typically are conducted in a carefully rehearsed and controlled meeting with the client, significant others, and perhaps a treatment professional. Interventions that do not include a professional may also be successful. During this meeting, members of the group express their concerns and feelings to the individual about his or her substance use. The goals of intervention are to alert the individual to the perceptions and concerns of the important people in the individual's life regarding her or his AOD use, and to convince the individual that the next step is to receive a formal screening and assessment by appropriate professionals.

Interventions can be powerful and effective tools for motivating an individual to enter treatment and for overcoming the denial of family and others about the individual's AOD problems. Moreover, interventions can take the form of social or institutional leverage. For example, pressure from the courts, probation officers, employers, schools, and families can be used to encourage the resistant individual to seek treatment.

Caution should be exercised when interventions are conducted by professionals who are also employees of the treatment program. Such a situation may discourage objectivity on the part of the intervention specialist, who may be overly focused on referring a client to his or her treatment program.

### **Educational or Vocational Services**

Increasingly, vocational training, general equivalency diploma programs, and job readiness training are being added to treatment programs, because of the needs of many clients to enter the job market. If programs do not offer these services themselves, they may link up with community agencies that can provide them.

### **Treatment in Criminal Justice Settings**

Effective treatment is being provided to offenders in the justice systems of some jurisdictions. Referrals to treatment as part of the social services offered by the probation or other corrections agency is standard practice in many locations. Assignment to a special AOD caseload as part of an intensive probation sentence is also becoming more commonplace.

### **Residential Criminal Justice Programs**

Community-based, residential programs are available as sanctioning options in many communities. Their use is growing, particularly as an alternative to revocation for probation and parole violators. Residential facilities can vary considerably in size, ranging from small halfway houses for 20 to work-release facilities that house several hundred offenders. The names of these programs vary as well. Depending on the jurisdiction, intended population, and purpose, the residential programs may be called: diversion centers, prerelease centers, halfway houses, work houses, restitution centers, and reentry houses. The facilities can be managed by the sheriff,

community corrections officials, the probation agency, private contractors, the parole agency, or the State corrections agency.

Treatment can be effectively provided in any of these programs. Whatever the setting, these treatment programs have some common characteristics:

- Their mission is to provide control and structure in settings that are less restrictive and less costly than either long-term residential treatment or incarceration, but that can still provide some measure of incapacitation.
- The goals for the offender-client are short-term, involving behavior change that can be initiated while the offender is in the setting and continued after he or she leaves and is on the road to rehabilitation.
- The programs incorporate a treatment plan and provide for case management, treatment, and employment and education services.

The offender in these settings must participate in treatment, must work or attend school outside, and must manage money to pay rent and other obligations such as restitution and child support. Some programs offer additional services to enable the offender to obtain a general equivalency diploma and acquire vocational and general life skills.

AOD abuse treatment is much more likely to succeed for offender-clients if all of these community-based facilities make available an array of services, including education, job training, opportunities for spiritual growth and development, and training in life skills. Programs should emphasize planning for relapse prevention and aftercare (care that continues after discharge from the treatment program). Many programs offer aftercare themselves. Offenders who complete the program can come back after discharge for continuing care or to attend Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings that are part of the treatment program. All continuing care plans, however, should link offenders with community resources that can be used to help them maintain drug-free lives.

### **Treatment Within Probation and Parole Supervision**

Probation and parole agencies are faced with increasing numbers of offenders under supervision who have been ordered to participate in outpatient AOD abuse treatment but for whom no treatment slots are immediately available. Many agencies have chosen to offer AOD abuse treatment within their own agencies. To this end, the agencies have secured training for their officers to become certified counselors and have begun to provide outpatient treatment of various intensities for the offenders under their supervision.

Having treatment services available onsite increases the ability of the agency and its regular agents to direct offenders into treatment in the absence of a court order: The treatment can be part of the overall supervision strategy. It can also be cost effective for the agency (or the court), since fees do not have to be paid to outside service providers.

There are those both in criminal justice and in the treatment community who question the wisdom of this approach. If the offender-client views the agency primarily as a punitive law

enforcement organization, treatment can be difficult, and few such agencies can offer the range of kinds of treatment services that are needed. Some in the criminal justice system also take the view that corrections and the courts ought to be advocates for increased treatment opportunities in the community for everyone rather than taking on the responsibility of making up for the insufficient treatment on the outside by providing it inhouse.

### **Specialized Caseloads**

In some jurisdictions, probation and parole agencies have responded to the increasing numbers of AOD-abusing offenders under supervision by creating specialized caseloads that group offenders according to a common characteristic or need for purposes of supervision. (As indicated earlier, specialized caseloads have been created to handle a wide variety of types of offenders.) Several types of specialized drug-offender caseloads have been established in jurisdictions around the country, and their use is growing. In some agencies, they are used in conjunction with agency-provided treatment services; in others, the caseloads are intended for offenders who are receiving treatment elsewhere in the community or who are in aftercare.

---

*AOD abuse treatment is much more likely to succeed for offender-clients if all of these community-based facilities make available an array of services, including education, job training, opportunities for spiritual growth and development, and training in life skills.*

---

Specialized caseloads have several common characteristics:

- A probation or parole officer providing the supervision who has the training needed to understand and respond to the needs of the offender-clients;
- Manageable client-to-officer ratios;
- A case plan, developed as part of the presentence or preparole investigation, that is adjusted regularly by the supervising officer;
- A focus on drug offenders;
- Case management, based on the agency's classification process, which is used consistently;
- Assessment for treatment provided by someone other than a probation officer, preferably before sentencing or parole; and
- The ability to call upon other professionals -- such as doctors, psychologists and other mental health professionals, teachers, job trainers, and financial needs consultants -- for additional assistance or services.

The best officers to handle these caseloads are those who understand the process of linking a variety of services together through case management and who can make connections to other professionals in the community for assistance.

Probation and parole officers responsible for specialized caseloads must have administrative support and the backing of their supervisors. The work is very draining, and many officers experience burnout as a result of their attempt to see that the needs of everyone in the caseload

are met. The issue of staff burnout should be addressed as part of the program's overall design. That design should include ongoing training and support for officers.

---

*The best officers to handle these caseloads are those who understand the process of linking a variety of services together through case management and who can make connections to other professionals in the community for assistance.*

---

### **Day Reporting Centers**

A typical day reporting center is a facility for people who are permitted to live at home, but required by the terms of their probation or parole to be at the facility for a specified period each day.

Some day centers function primarily as staging areas from which offenders are sent out in work crews to perform manual labor in the community: cleaning highways, painting schools, and the like. Others offer chiefly educational opportunities. In many jurisdictions, however, day centers have become day treatment centers whose primary mission is to provide outpatient AOD abuse treatment of various intensities. That treatment may be provided by public or private treatment agencies, or by staff of the correctional agency. Day centers can, of course, offer a combination of these activities plus additional ones.

### **Home Confinement**

Home confinement can be ordered as an accompanying condition with any of the other nonresidential programs described here. The offender must remain within his or her home except for the specific times or activities permitted by the court or paroling authority. Home confinement or curfews are often monitored by means of electronic devices that permit parole or probation agents to verify their presence in (or detect their absence from) the house.

Both home confinement and day reporting centers provide significant restrictions on offenders' liberty and opportunity to commit crime, but are not as restrictive or punitive as a residential program or incarceration. At the same time, they permit the offender-client access to a wider array of treatment options than might be available in a residential correctional setting.

### **Self-Help and Support Groups**

An important adjunct to treatment is the self-help group, including 12-step programs. Self-help groups, however, are not treatment programs. The best known are Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous. Many treatment programs are based on what is called the 12-step model of treatment, and attendance at 12-step programs is required of people in treatment. All 12-step programs are modeled after the earliest -- AA -- which is a spiritually based program of recovery. Members "work" each of the 12 steps, which means making each

step an inherent part of one's life. Persons who have difficulty with the spiritual basis of AA may prefer other self-help groups such as Rational Recovery or Women for Sobriety. Self-help groups are sometimes established based on ethnicity or gender. No matter who belongs to them, self-help groups are separate from either treatment or the criminal justice system, and they are operated by their members.

In the early years of efforts to overcome alcohol and drug abuse, the self-help groups, particularly AA, were the only resource available to persons with AOD abuse problems, and they are still recognized by virtually all treatment programs as a very significant and necessary adjunct to treatment.

The criminal justice system has recognized the importance of AA, NA, and the others. Many judges require offenders to attend them as a condition of their sentences; parole boards often require attendance as a condition of parole release. In a few localities, AA and NA have allowed monitors to sit outside to ensure that offenders attend meetings. AA or other 12-step groups can be provided in a justice institution or community-based facility in conjunction with treatment or as part of the recovery plan.

## Endnotes

<sup>1</sup>The section on levels and types of treatment is adapted from the Treatment Improvement Protocol *Guidelines for the Treatment of Alcohol- and Other Drug (AOD)-Abusing Adolescents* published by the Center for Substance Abuse Treatment.

<sup>2</sup>The number of treatment hours is taken from the American Society of Addiction Medicine's (ASAM) *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* and is offered as a working prototype. Some States have developed licensing regulations that dictate the number of hours associated with different levels of outpatient care. These hours, therefore, are only guidelines and may need to be altered to be consistent with State licensing regulations.

<sup>3</sup>Adapted from ASAM criteria.

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Chapter 4 -- Combining AOD Abuse Treatment and Intermediate Sanctions**

Successfully combining alcohol and other drug (AOD) abuse treatment and intermediate sanctions requires sufficient, flexible services; good information; well-informed collaboration; and mutual understanding.

#### **Securing the Most Appropriate Treatment**

There are several basic prerequisites for ensuring that courts make the optimum use of AOD abuse treatment in the context of intermediate sanctions and that offender-clients get the treatment services that they need.

First, judges, prosecutors, probation agencies, and defense attorneys need a reliable, easily accessible means to assess the treatment needs of the offenders for whom they are choosing sanctions. These assessment services may be provided through an interagency agreement with the State AOD agency, by specially trained probation officers, or by contract with another outside agency. The assessment process should produce an individualized plan for comprehensive AOD treatment, along with recommendations for appropriate and available treatment services.

Second, an array of intervention strategies and treatment modalities should be available to the court for use as part of the sanctioning package. If choices are limited, then some offender-clients will receive treatment that is inappropriate or ineffective for the developmental stage of their illness.

Third, the services must be expansive and flexible to meet the many needs of offender-clients. The more responsive programs are to all of these needs, the more likely that the overall outcome will be positive for the offender-client.

Fourth, programs that provide treatment must be willing to work with court and criminal justice decisionmakers to explain the possibilities and the limitations of their services. Such interaction can help ensure appropriate referrals and more accurate expectations and help maintain the credibility of both the programs and the treatment system.

Fifth, education needs to be provided to judges and other criminal justice decisionmakers to help them understand the typical behavior patterns of AOD abusers and respect the system of incentives and consequences employed by treatment programs to respond to client behavior. This information will help the court maintain realistic expectations of offender-clients in treatment and prevent inappropriate justice system responses to that behavior.

One of the most frequent mistakes in treatment is to place patients in treatment programs that are not appropriate to the developmental stages of their illness. Misreferrals often result when there is a waiting list of prospective clients, and each is placed in the particular opening that comes up, irrespective of the type or phase of treatment offered.

For example, a moderate drug user who recognizes the threat of drug abuse to his life and wants to quit can be doomed to failure by placement in a residential program. All he may need is education and counseling provided in an outpatient program. It is inappropriate to ask him to leave his family, forget the outside world, and learn how to live within the controlled environment of a treatment center. Because treatment and activities in the residential center are very restricted, misdirected clients are likely to become hostile and their treatment fails. Such offenders should be referred to outpatient treatment for a specified number of hours a week, thereby keeping their family system intact.

This type of misreferral happens frequently in the justice system because of the system's need to balance competing or conflicting goals in crafting a sanction. An offender who commits a relatively serious offense but whose AOD abuse problem is only moderate poses a dilemma to the court. In the interest of adequately punishing the serious offense (and/or limiting his or her access to the street) and of treating the offender's underlying problem, the court might choose a sentencing package that includes long-term, residential treatment even though the offender-client's problem does not warrant such a restrictive, intensive response.

It is possible to deal with these dilemmas, but all of the parties (judges, prosecutors, defense attorneys, probation staff, and treatment providers) must agree on the goals and outcomes for specific groups of offender-clients. The offender groups must be clearly identified by types of crimes, criminal history, and demographic characteristics. For example, a jurisdiction may need a residential facility that provides both intensive and nonintensive AOD abuse treatment for male offenders, over age 30, with multiple felony convictions, and a current felony property conviction. Such a facility would offer significant restrictions on liberty, severe limitations on residents' opportunity to commit crime, and a variety of treatment responses. At the same time, the jurisdiction might also need a day treatment center that offers intensive outpatient AOD treatment to offender-clients who do not require as much punishment and/or incapacitation. *The jurisdiction must determine the types of offenders for whom it wants to provide treatment and the relative priority of treatment among other criminal justice system goals.*

## **Effective Treatment Requires Collaboration**

Experience gained to date in the provision of treatment to offenders suggests the critical importance of collaboration and effective communication between the justice system and the

AOD abuse treatment system. Indeed, experience shows that working together needs to be a major goal if effective treatment is to be provided to offenders.

Because treatment is part of the health care and social service fields and focuses on the "whole person," treatment providers are more interested in the person than in the crime committed and its consequences. In contrast, the criminal justice system focuses on the person within the context of the whole community: What harm has been caused by this person and to whom. What are the consequences of her or his continued presence in the community. What is the message to the community if we do or do not incarcerate her or him. The justice system's primary concerns -- and responsibilities -- are the larger society and its safety.

Treatment is concerned with determining what led to the individual's overall behavior as well as the crime, with the hope that understanding can lead to changes in that behavior. Treatment personnel speak of holistic treatment, meaning that if they can deal with all the issues pertinent to the individual's behavior and values, it will be possible to treat her or him in a manner that leads to elimination of the undesirable behavior.

The justice system is usually just as concerned about changing undesirable behavior. The chief difference is the origin of the concern: The justice system wants a safer community, and the treatment provider wants a healthier individual. In the end, both can acknowledge that treatment is a necessary means to protecting society by addressing individual problems that lead to crime.

While the desired result -- the individual in recovery and leading a life free from crime -- may be shared, the two systems operate from very different concerns and responsibilities. These in turn produce very different operating principles, values, and procedures. While collaboration cannot do away with these differences, nor would we want it to, it can help to overcome the unnecessary barriers and misconceptions that hamper effective service delivery, the shared goal of the two systems.

---

*The justice system wants a safer community, and the treatment provider wants a healthier individual. In the end, both can acknowledge that treatment is a necessary means to protecting society by addressing individual problems that lead to crime.*

---

## The Ingredients for Successful Collaboration

Some guidelines can be provided for agencies that attempt to work together:

- Ensure that personnel in the treatment system understand the intent of sentencing for each offender.
- To avoid "turf" problems, ensure that those in each system clearly understand the scope and responsibilities of both the justice and treatment systems.
- Understand the other system's view of the individual offender.

- Be clear about which system's discipline will prevail in which situations.
- Communicate clearly and work to develop a common language.
- Understand how perceived treatment failures can constitute a violation of the law.
- Agree on the features of the case plan.
- Understand the terms and conditions facing the offender-client.

## **Understanding the Intent Of Sentencing**

The justice system endeavors to ensure that sanctions are consistent with the intent of the sentence. In considering collaboration, the question of the goals of sentencing becomes very important. Treatment personnel need to ask, "What is the court trying to achieve for this individual by this sentence?" Too often, issues of intent are not discussed and only later do justice and treatment discover that they were starting from different premises.

The intent and goals of sentencing come into play on two levels. First, it is crucial that treatment providers understand the full terms and the purpose of the sentence in each case in which they are involved. The more specific the court can be about the outcomes that are desired, the easier it will be for the provider to meet those expectations. This may require that the program or counselor contact the court (starting with the judge's clerk or bailiff) or the probation officer to get this information.

*The more specific the court can be about the outcomes that are desired, the easier it will be for the treatment provider to meet those expectations.*

The criminal justice decisionmakers in each case have a responsibility to spell out what they want to happen with the offender and why. It is not enough to agree or order an individual "to get treatment" or even "to get outpatient treatment." The order or agreement should articulate how often treatment is to be provided (daily, three evenings a week, or whatever), in what kind of setting (a residential treatment facility, a residential criminal justice facility, an outpatient facility, a day treatment center, and so on), and to what extent other goals besides treatment have been set. For example, it should be clarified whether the offender has been ordered to report to a day treatment center because the assessment indicated she or he needs that intensive level of treatment or because the decisionmaker wanted her or him kept off the street for 8 or 9 hours a day or both.

Second, the justice system decisionmakers responsible for crafting sentences in individual cases -- the judge, prosecutor, defense attorney, and probation officer -- must understand the capabilities and limitations of the treatment program's services. They must be familiar with its procedures to the extent that these will affect the court's expectations. In the example cited above, the day treatment center or day hospital may not be able to offer the level of security the court desires. If the court is not familiar with the specific features of that program, the level of incapacitation that was intended for the offender-client may not be achieved. This can have a negative effect on the perceptions of justice system personnel regarding treatment providers.

Treatment providers have to be responsible for informing judges, parole agencies, and other justice system decisionmakers about available treatment programs and what they can and cannot accomplish.

---

*Treatment providers have to be responsible for informing judges, parole agencies, and other justice system decisionmakers about available treatment programs and what they can and cannot accomplish.*

---

### **Understanding the Impact of Differing Goals**

Opportunities for disagreement are frequent in any case in which treatment providers and the criminal justice system are both involved. Nowhere are those opportunities greater, however, than when a treatment program is operated within a residential corrections facility such as a prerelease center or work house. The offender-client in treatment in such a setting may feel like the child who has two parents who do not always agree on what the rules are and how they are to be enforced.

Such disagreements typically arise when the goals and objectives of the two systems are in conflict. Within a correctional facility of any kind, the primary responsibility of its managers is security. This includes protecting the security of the surrounding community by controlling the whereabouts of offenders at all times, and protecting the security of the offenders by having an orderly, clean, and well-controlled facility. For treatment providers, whether they are employees of the facility or outside contractors, the responsibility of assisting offender-clients through the difficult and painful process of recovery may mean wanting the rules to be flexible and facilitative of what is best for the individual client.

While the treatment provider has to understand that security is the chief priority within a correctional facility, the corrections staff can appreciate that a successfully treated offender is less likely to commit crime following release. One step that can foster collaboration and success is the establishment of interdisciplinary teams to work together to make decisions based on the best information.

### **Understanding That Treatment "Failure" Can Violate the Law**

To the treatment provider, relapse is a step in the process of recovery. To the court, it may be considered a violation of the law or a violation of the conditions of the sentence. The two communities need to better understand each other's positions on factors such as relapse.

When an offender-client receives a sanction that includes treatment, a perceived program failure can constitute grounds for revocation. Missing scheduled outpatient treatment may be considered a violation of probation or parole by those in the justice system, while treatment personnel may view it as part of the denial process, a common condition in treatment and recovery. Such distinctions need to be discussed and clearly understood, both by those working in treatment and by those working in justice, as well as by the offender-client. A treatment contract should cover

issues of negative behavior, as well as the rewards associated with compliance and eventual successful completion.

If the probation department and the court have made a referral to a treatment provider, the issue of program failure has to be addressed when the memo of understanding or other agreement is developed, so that an agreed-upon, common response can be developed.

The use of contracts is very important to inform the offender-client clearly what the consequences will be if she or he is found to be noncompliant with rules and regulations. The offender and the treatment provider must understand what behaviors will get her or him back in court or lead to a different sanction. Guidelines might be clearly stated as follows:

- Every program has a set of rules and expectations, and the client will be in jeopardy if he or she fails to comply with those rules and expectations.
- Any law violation means the client-offender is in jeopardy status.
- Compliance with all the conditions of probation or parole, particularly special conditions arising from the offender's crime, is mandatory.
- Failure to appear in court as directed constitutes a violation of the law.

In addition, all due process protections for offender-clients must be specified in writing.

The failure to comply with the requirements of a treatment program does not have to mean automatic revocation. One program has had success with using defense counsel to intervene. When a violation occurs, the program informs the defense counsel who negotiates with the district attorney, the probation agent, and the treatment personnel, functioning as an advocate for the offender in bringing about alternative sanctions, such as intensifying the treatment.

### **Communicating Clearly With a Common Language**

Collaboration between the justice and treatment systems to achieve more effective treatment for offenders requires that the two work together to achieve clarity in both their communications with each other and their joint communications to the public, legislators, and other policymakers.

The criminal justice system has to examine its own jargon, which is full of the language of prison and punishment. In fact, however, most offenders under correctional supervision are in the community, not in prison. The public has not been educated to realize that everyone who goes to jail and almost everyone who goes to prison will return to the community. Many will be released within months of their original sentencing. Legislatures have responded to public fears by enacting tougher sentencing laws, but this has only added to the public's misperceptions about the terms that most offenders serve. (Lest this document contribute to misperceptions, we want to be clear that there are tens of thousands of inmates all over this country who are serving and will serve extremely long sentences in prison. In terms of all inmates who are admitted to prisons and jails in any period of time, however, most will serve relatively short terms.) If the criminal justice and treatment communities want to increase the opportunities for effective treatment for offenders, one of their first collaborative efforts should be to help educate the public about the realities of offenders in the community.

---

*If the criminal justice and treatment communities want to increase the opportunities for effective treatment for offenders, one of their first collaborative efforts should be to help educate the public about the realities of offenders in the community.*

---

Such an effort is necessary to advocate for the treatment needs both of offenders in the community and of those in custody, since the latter will, in all likelihood, soon be returning to the community. Offenders and corrections officials need to be reminded of this as well: Incapacitation and rehabilitation are not mutually exclusive. If an AOD-abusing offender is going to serve time in an institution, it makes far more sense to focus on enabling her or him to be able to function back in society than to concentrate on making her or him into a "good inmate" who can survive within a correctional institution.

Language is also very important to communication between the two systems. Miscommunication can occur when common words are believed to have a universal meaning but, in fact, do not. "Classification," for example, is used by criminal justice practitioners as if it were synonymous with "assessment," which is the expression used most commonly by treating professionals. The differences in these terms are important. Classification usually refers to a system for determining how much supervision an offender requires because of the risk she or he represents. Assessment is usually associated with a determination of the social, psychological, or healthcare needs of an individual. Criminal justice agencies also conduct clinical assessments for their own service delivery systems.

Relapse prevention is another commonly used term that generates much confusion between the two systems. Some in the criminal justice field assume that relapse prevention requires -- and therefore means -- increased surveillance to deter AOD use. Their belief is that if you increase their chances of getting caught, offenders will not relapse. To treatment providers, relapse prevention is problem solving -- a process of understanding the individual's patterns of AOD abuse and the pressures or triggers that can cause it, and then creating individualized strategies to deal with those issues.

### **Supporting the Goals of the Treatment Plan**

Corrections agencies must have policies and practices in place that foster understanding of the goals of treatment and the treatment process, and that support the role of the treatment program as a partner in carrying out the case plan for each offender-client. If these are left to the discretion of each officer, problems will result. An offender under the supervision of one probation officer, for example, may be progressing in treatment very well. He or she may then be transferred to another officer who may not understand or support treatment and who may have the attitude that, "You screw up one time, partner, and you are back in the slammer." The intent of treatment in this case may be jeopardized.

Many probation and parole officers embrace treatment options as being absolutely essential, but there are others who doubt treatment's value. Treatment programs must educate corrections agencies about treatment and their individual services. The burden, however, should not fall exclusively on the treatment providers. Corrections agencies have an obligation to develop uniform policies and training for their staff in this critical area.

### **Understanding the Offender-Client's Terms and Conditions**

It is rare for the client in probation not to be facing other terms and conditions in addition to participation in the AOD abuse treatment program. Typically, the terms and conditions of probation or parole might include:

- Obey all laws.
- Submit to search and seizure.
- Participate fully in the AOD abuse treatment program.
- Perform 300 hours of community service.
- Pay restitution to the victim of \$1,000, in monthly payments.
- Pay fines associated with the crime.

In the absence of communication and good case management, both the treatment provider and the officer supervising the offender-client may misjudge the extent of the terms and conditions facing the client, causing her or him to be overburdened and increasing the likelihood of treatment failure.

For example, an offender-client who is doing well in treatment and meeting all other terms and conditions may fail to make monthly payments for restitution for a period of several months. A probation officer who is unfamiliar with the requirements of the client's treatment may take punitive action such as increasing the amount of each restitution payment to make up for the missed ones. This will require the offender to work many more hours a week and may negatively affect his or her ability to progress in treatment.

Treatment and probation and parole personnel need to cooperate to prioritize goals and to make sure the client is not overburdened by the sheer number of requirements. Many offender-clients have been unable to handle much responsibility or meet regular commitments in the past, which may be part of the reason for their current situation.

### **Good Case Management Practices**

Virtually all of the elements that have been discussed as necessary to collaboration between the treatment and justice systems can be included as elements of good case management. A case management approach assumes that the criminal justice agency and the treatment provider view themselves as partners in a common effort to get the offender-client in recovery from AOD abuse and living a crime-free life. From that starting point, justice system practitioners and treatment personnel can cooperate in setting goals for the offender-client, responding to undesirable or violation behavior, and adjusting the terms of probation or parole and/or the type and intensity of treatment.

Good case management begins with good information: information about the other agency; its responsibilities, policies, and practices; and its expectations of its clients. This information can reveal important and necessary differences between the agencies and can help build respect for their complementary roles.

Collaboration and case management between treatment providers and probation and parole agencies can be fostered in many ways. One approach that has been used successfully invites the probation/parole officer to be present during the client-offender's intake process, which gives the officer insight into the client's problems. Case discussions between the officer, the treatment provider, and the client-offender can be scheduled monthly. This gives both professionals insight into the client's situation and full range of conditions and prevents the offender-client from manipulating one person against the other. Using this approach, the officer and the treatment provider share power and decisionmaking.

When treatment and justice personnel have developed collaborative working relationships, their response to negative behavior, such as relapse, is based on trying to achieve their common goals for the offender-client. The criminal justice system is much more likely to trust clinicians to make decisions; treatment personnel are more likely to base their decision on clinical grounds with full consideration of security and public safety.

In jurisdictions where good case management is practiced, the probation/parole officer and the treatment provider might consider preparing joint reports or appearing together before the court or parole board to address issues pertaining to the offender-client's progress. This kind of feedback can be helpful to those decisionmakers, not only in deciding the immediate case, but also in making well-informed decisions in future cases.

## **Licensure: A Concern of the Justice Field**

### ***Program Standards***

Criminal justice practitioners are concerned about the licensing of treatment programs. This concern typically arises when the justice system has had experience with a treatment provider or program of poor quality.

Treatment programs with funding from the State or Federal Government must be licensed. Programs that operate with private funds do not have to meet recognized AOD abuse treatment standards. The writers of this TIP recommend that individual States standardize facility requirements and establish minimum requirements for treatment services that would be applicable to all treatment programs.

As part of that regulation process, States should require licensure and monitoring by the State AOD agency or a recognized State board. The responsibilities of the agency or board should include overseeing and monitoring facilities. Programs should be required to meet minimum treatment standards, and the State should determine that they are competent to provide services through a formal evaluation procedure established by the regulatory agency.

Criminal justice system personnel are also concerned about the outcome of a particular treatment program or modality. While licensing cannot guarantee a successful outcome, ensuring that minimum standards are in place and that quality assurance is addressed are necessary first steps. It would also be helpful if criminal justice practitioners could regularly receive information about the program, the client profile, and the population the program is designed to serve.

### ***Standards for Treatment Staff***

In some States, counselor associations provide the certification of treatment personnel or use national certifying bodies. There may be no enforcement, however, from the State agency regarding this certification. The State AOD agency may lack the authority to certify and regulate AOD counselors, thus prohibiting the State agency from requiring such certification. In other States, voluntary boards that are not part of the State AOD agency may provide certification. In either case, the agency or board should license and regulate private-sector program personnel as well as federally and State-funded personnel.

The issue of using ex-addicts or ex-offenders as counselors also needs to be addressed. They may make very good counselors, but they need also to be qualified by virtue of training and certification.

The problem of unregulated programs and treatment providers is especially important to criminal justice practitioners whose agencies may face political pressure to use particular programs. The result may be that clients are placed in substandard treatment for which the daily rate paid by the criminal justice system is the same as that paid to a program offering top-quality and up-to-date services.

### **What Treatment Providers Need to Understand**

Providing AOD abuse treatment to offenders through intermediate sanctions is far more likely to be effective if treatment staff understand the criminal justice process. It is important, for example, to distinguish between the authority of a written court order requiring treatment and the spoken statement of a probation officer who says, "I don't think you are doing well, and I want you to go to this treatment program."

Understanding the criminal justice process and the individual offender-client's stage in the process are necessary elements of effective treatment planning. The length of time the offender is to be in treatment, the exact terms of the order or condition, the nature of the offender's accountability and the authority accountable to, and the consequences of behavior are critical pieces of information for the treatment provider. The more the provider knows and observes about the criminal justice system's expectations and needs, the more likely it is that criminal justice system decisionmakers will develop confidence in the treatment program and accept the program's rules and procedures for accountability.

As noted above, good case management practices between the two systems will contribute greatly to this understanding, cooperation, and mutual trust. The treatment program needs to know that it can proceed with treatment, respecting the accountability needs of the criminal

justice system and receiving respect for its judgments about the appropriateness of criminal justice intervention.

#### Critical Information for the Treatment Provider

- The length of time the offender is to be in treatment
- The exact terms of the order or condition
- The nature of the offender's accountability and the authority accountable to
- The consequences of behavior.

For example, if a client seems to be in a strong recovery, progressing well, and then relapses, program personnel should have confidence that the court decisionmakers will view the relapse as they do, as part of the process of the disease, and will allow the program to design or develop the appropriate response, either in conjunction with the court or with its approval.

Unfortunately, many providers tend to shy away from providing services to offender populations because they fail to understand that the justice system population is really not new to them. For the most part, offender-clients are people from the same communities as those now receiving treatment from these providers. The disease has simply progressed further among offenders: They were willing to engage in criminal activities to support their habits or were caught possessing or using drugs. Many of the offenders in need of treatment, in fact, may have been in treatment before and may be known to staff of treatment agencies. Enhanced demand reduction efforts have resulted in many more individuals being arrested and incarcerated. These individuals are now in the criminal justice system rather than in our city streets.

Many providers have also been intimidated by public policies that have identified drug abusers in the criminal justice system as a menace and too severely ill to treat. After working with this population in the justice system environment, many treatment providers find that, as a group, offenders are very responsive to treatment because they have been close to "bottoming out" in their disease or have already done so ([see Chapter 3](#)). Their motivation for treatment is often very high.

Treatment programs have to provide some services to the court or correctional agency that are not ordinarily required for other clients. Treatment providers may be asked to participate in surveillance, monitoring the resident, and maintaining contact with employers or training programs. These tasks are usually straightforward, and accepting them as part of the treatment provider's responsibility helps gain the support of the justice system for treatment. Many clinicians resist these tasks at first, but then find that when they incorporate joint case management into treatment, they have a better understanding of their offender-clients.

### What the Justice System Needs to Understand

Treatment programs and the treatment field have not existed long enough to predict specific outcomes for each program. Treatment practitioners feel that they are being pushed to become

more accountable for results at a time when the field is still defining itself. Crime and the relationship between crime and drugs have increased the pressure on the treatment field to become more accountable for the outcomes of its programs.

Providers are called upon to forecast what will happen to the client as a result of taking part in particular treatment activities, but they often do not know for sure. They should be clear that the treatment field is still studying treatment outcomes and identifying factors that lead to effective treatment. The CSAT Treatment Improvement Protocol series, of which this document is a part, is an effort to inform providers of the best thinking, practices, and research in the field.

Treatment providers also need to keep abreast of new studies from the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Addiction, and private groups such as the Center on Addiction and Substance Abuse at Columbia University. As study findings emerge, treatment providers should keep their counterparts in the justice system informed. Once the criminal justice field knows more about treatment outcomes, it will be better able to support treatment as part of intermediate sanctions.

Law enforcement has begun to acknowledge that punishment and prisons alone are not going to solve society's problems with AOD abuse. Many law enforcement administrators now recognize the positive contributions of treatment, and national figures in the criminal justice field are speaking out about the need for increased support for treatment.

That support, however, depends on two things: criminal justice system leadership that will advocate for treatment and Federal and State funding to establish treatment programs.

## **The Need for More Research On Treatment**

To know what types of clients, offenders or not, are most likely to benefit from what types of treatment, good studies on treatment matching are needed. The research to date, is not consistently clear about what works, and more studies are called for.

Attempts have been made to identify criteria for success at 1-year followup, such as: 1) continued abstinence, 2) no arrest or rearrest for AOD-related offenses, and 3) evidence that AODs are not creating any other problems in the person's life. The offender does not have to attain success in all three areas: one can relapse and still be considered a success in treatment. In at least one State where these three measures were used to follow offenders, it was found that about 40 percent remained abstinent, about 40 percent were not arrested or experiencing other life problems, and about 20 percent were not helped ([Colorado Department of Health, 1992](#)).

---

*As study findings emerge, treatment providers should keep their counterparts in the justice system informed. Once the criminal justice field knows more about treatment outcomes, it will be better able to support treatment as part of intermediate sanctions.*

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Chapter 5 -- Issues in Combining Treatment and Intermediate Sanctions**

For alcohol and other drug (AOD) treatment and intermediate sanctions to be combined effectively, the criminal justice system and the AOD abuse treatment system must cooperate and collaborate on two levels. First, they need to develop and manage joint interventions into the lives of individual offender-clients that respond to the individuals' intertwined problems of criminality and AOD abuse. Second, to deliver more productive services to their shared clients, they need to create shared programs and procedures that span their respective systems. The systemic approach to collaboration is a necessary prerequisite to developing a workable programmatic intervention for AOD-abusing offenders.

This chapter explores major issues related to collaboration between the two systems in the development and implementation of effective intermediate sanctions programs. First, differences in perspectives and goals of the two systems are described. Then guidelines for forging an effective partnership between agencies are outlined. Specific problems and needs of the offender-client population are considered next, and strategies for engaging these clients in treatment are presented. Included also is a discussion of case management, an essential ingredient of effective intermediate sanctions programs. Combining AOD treatment with intermediate sanctions raises many ethical issues, especially related to the allocation of scarce resources. These issues are also discussed, as are several major obstacles to the effective use of intermediate sanctions.

### **The Attitudes and Perspectives of the Two Systems**

As discussed earlier, the criminal justice system and the AOD treatment services system operate with different goals. In combining treatment and intermediate sanctions, the two systems work toward joint ends with the same group of offender-clients. Those efforts are far more likely to be successful if the two systems understand and acknowledge their different responsibilities and goals, and work to find common ground that will allow each to be successful in meeting them.

One of the primary differences between the two systems is the focus of responsibility. The criminal justice system is charged with carrying out justice and maintaining public safety; the AOD abuse treatment system with helping individual clients recover. The criminal justice system's responsibility for public safety requires supervision and surveillance of offenders; the

treatment system attempts to influence or modify clients' behavior in the least restrictive manner possible, consistent with treatment needs.

Such differing responsibilities lead to very different views of and relationships with offender-clients. The treatment system depends on engaging the client psychologically and developing a therapeutic alliance between the treatment provider and the client. The criminal justice system's interaction with the offender is bifurcated: On the one hand, this individual must be watched as a potential threat to others; on the other, he or she is a human being in need of help. The criminal justice system, by making treatment part of the offender's sentence, makes treatment part of sanctioning his or her prior behavior. To the treatment system, treatment is not punishment, but exists to serve the best interests of the client. These differences in responsibility and intent can obscure and impede the abilities of the two systems to work together toward common goals.

Their ability to work together successfully is further impeded by old misperceptions and misconceptions that continue to exist among professionals and staff within the two systems. Although they have been dispelled in some communities through cooperative programs and efforts, it is probably helpful to acknowledge what those are so that we can move forward.

Treatment professionals often believe that the criminal justice system is overly focused on punishment and control to the detriment of considering the client as a whole person, as one who needs rehabilitative treatment for a verifiable disease. In fact, the criminal justice system and its practitioners have an absolute responsibility to be vigilant about any indication that an offender may pose a threat to the community: A minor infraction may be indicative of an emerging pattern of law-breaking.

It seems to many in the treatment community that criminal justice practitioners lack information about AOD abuse treatment and, therefore, about the cost of treatment. Treatment requires resources, and the criminal justice system in most jurisdictions lacks the funds needed to provide for all the clients that they mandate to treatment. Thus, the issue of resource availability is another source of systemic conflict that can potentially impede collaboration.

Some criminal justice professionals seem not to believe that substance abuse is a disease. Whether because of this disbelief, or their lack of understanding of AOD abuse, especially its physiologic aspects and pattern of relapse, criminal justice practitioners may impose mandates and conditions that have the unintended effect of setting up offender-clients to fail in treatment. The "piling on" of sanctions or conditions that can conflict with treatment has the effect, in turn, of making the criminal justice system seem uncommitted to the long-term process of treatment, recovery, and rehabilitation.

---

The "piling on" of sanctions or conditions that can conflict with treatment has the effect of making the criminal justice system seem uncommitted to the long-term process of treatment, recovery, and rehabilitation.

---

Finally, the criminal justice community may be seen by the treatment community as uninterested in developing working partnerships with the treatment community, as being overreliant on control, and as working according to a military model.

Criminal justice system practitioners, on the other hand, often believe that treatment professionals pamper offenders, that they are uninformed about criminal justice issues, and that they are not concerned about public safety. In this regard, treatment professionals are also accused of using AOD abuse confidentiality requirements to hide client information vital to the justice system.

Criminal justice system professionals may also believe that the treatment community has little interest in working with offender populations because those populations are more difficult to treat than other groups of AOD abusers, are less compliant with program rules, and represent a greater risk of failure for the treatment providers. Criminal justice system practitioners perform a difficult job with a difficult group of people. It is understandable that they believe that others do not want to work with this population. Treatment professionals are also seen as unwilling or unable to stretch the boundaries of their treatment plans and programs to accommodate the requirements of the criminal justice system and its offender-clients.

For the two systems to work together to address the problems and rehabilitation needs of offender-client populations, perceptual and philosophical differences must be confronted and overcome. Working collaboratively, the two systems must identify and target priorities, find ways to meet identified priorities, plan programs and services with attention to pooling available resources, and achieve minimum standards for the treatment and supervision of offender-clients.

An agreement or contract between the two systems is one means to begin this collaboration. Working on such an agreement between the two systems will facilitate, if not mandate, the consideration of their different concerns and practices, and will force discussion of how the two systems can most effectively address the requirements of the offender population in need of treatment.

## **Building an Agreement**

Given the enormity of the current need for AOD treatment for offenders, developing collaboration between the two systems is both vital and a major challenge. Combining AOD abuse treatment with intermediate sanctions requires a partnership that is systemic and that integrates the goals and objectives of both systems. Developing and implementing an agreement to guide their common work is a key step in building this partnership. The development process can serve to focus the discussion and to record the shared goals, intentions, and responsibilities of the criminal justice and treatment communities.

It is recommended that the two systems finalize their understanding in a formal agreement between the treatment agency and the criminal justice agency. The suggested components of such an agreement are listed in [Exhibit 5-1](#). These elements are inclusive but not exhaustive, and will necessarily be augmented or modified according to locality.

## **Participation in the Process**

All participating parties must be represented in the development of the agreement. In addition to the corrections agency and the treatment provider, judges, prosecutors, and other decisionmakers from every component of the criminal justice system should be involved in the discussions. If the treatment program will be utilized by more than one corrections or court agency (probation, parole, community corrections, the jail, pretrial services), then each one should be represented in the process of developing an agreement.

If all the members do not participate in the process, the intermediate sanctions programs are less likely to succeed. The constraints, limitations, or needs of one or more of the involved agencies will inevitably be overlooked or inaccurately considered, and as a result, the intermediate sanctions program may be underutilized or used inappropriately. This diminishes the credibility of intermediate sanctions and AOD treatment for offenders.

## **Definition of Responsibilities**

For the two systems to collaborate in a well-integrated manner, there must be concrete definitions of the following areas:

- The two systems' reciprocal expectations and needs
- The roles assumed by specific actors in each system
- The responsibilities assumed by each system, and how these will be accomplished.

## **Training**

Cross-training is an important step toward making professionals and staff in both systems aware of the constraints, operating procedures, and requirements of the other. The agreement between the two systems informs the interaction between staff in the two systems and is a basis for cross-training.

## **Treatment Noncompliance**

AOD treatment and criminal justice system professionals should agree on which behaviors call for criminal justice intervention and which can be handled within the treatment program. Clarification of this critical issue ensures that there are clear, appropriate, and enforceable consequences of infractions while offenders are in treatment, and that the consequences are consistently and uniformly imposed.

A focus on the behavioral outcomes that both systems want for offender-clients will facilitate decisions about how to respond to noncompliance. The choice of response can be based on whether it will produce a desired outcome. Positive change or progress in behavior, rather than avoidance of rule-breaking, should be the joint goal.

---

*Positive change or progress in behavior, rather than avoidance of rule-breaking, should be the joint goal.*

---

For most offender-client infractions, penalties imposed by and within the treatment program are sufficient responses. More serious infractions require criminal justice sanctions. The offender signs a client agreement that identifies behavior that constitutes an infraction and outlines the possible responses to those behaviors. (The client agreement is different from the interagency operations agreement and is discussed later in this document.) But first, the two systems have to negotiate and agree on these sanctions and on the occasions when they will be used.

When the behavior in question constitutes a new crime, the criminal justice system will, in all likelihood, respond unilaterally. In the agreement, treatment providers may want to include an item ensuring that their role in the offender-client's life will be recognized; for example, they may ask to be notified by the criminal justice system if the offender-client is arrested. However, since there are so many law enforcement channels through which an offender can be apprehended, arrested, and booked, it may be difficult for criminal justice system practitioners to guarantee notification. It may be helpful for treatment providers to realize that criminal justice agencies themselves have trouble staying informed about actions taken by other agencies or parts of the system against offenders under their supervision. Few jurisdictions at this point have the kind of integrated information system that tracks all criminal justice activity relative to specific individuals.

### **Transmission of Information**

To facilitate the collaboration, treatment providers must be responsible for reporting critical incidents to the criminal justice agency supervising the offender-client. (The definition of a "critical incident" will presumably have already been decided through the agreement process outlined earlier.) Failure to do so will undermine the use of treatment and intermediate sanctions. The criminal justice system, for its part, must understand the importance of treatment continuity and avoid unilateral action that disrupts the hard work of treatment unless such action is absolutely necessary. For example, a unilateral decision to revoke an offender-client to jail or prison for a so-called technical violation of probation (when the offender fails to comply with the conditions of probation, such as missing an appointment with the probation officer or breaking curfew, but does not commit a new crime) may undermine both the treatment process and the cooperation between the agencies.

---

*To facilitate the collaboration, treatment providers must be responsible for reporting critical incidents to the criminal justice agency supervising the offender-client.*

---

Understanding and supporting treatment continuity does not mean that criminal justice agencies are expected to ignore such violations. It does mean that they will work with treatment providers

and their own colleagues to develop other responses to violation behavior short of revocation to jail or prison. Such alternative responses are useful and appropriate in many cases and for a variety of violations.

In addition to agreements about *when* a treatment provider should communicate with the supervising criminal justice agency, *the content* of that communication should be clarified. Federal rules regarding client confidentiality must be observed, and some information is not appropriate to communicate to criminal justice agencies. (See [Chapter 7](#) for a full discussion of client confidentiality issues.) Treatment programs usually provide progress reports to other agencies that include minimal therapeutic detail regarding a client's disclosures in treatment, but instead describe general observations about the client's progress in treatment.

---

*The criminal justice system must understand the importance of treatment continuity and avoid unilateral action that disrupts the hard work of treatment unless such action is absolutely necessary.*

---

The content and frequency of treatment programs' reports to criminal justice supervision agencies and the related issues of confidentiality requirements should be covered in the interagency agreement. These topics should also be included in multi-agency cross-training.

### **Management of Ancillary Services And Referrals**

Offender-clients need a diverse array of other services to help them attain and sustain a stable life. These may include child care, transportation to treatment, job training and placement, health and mental health care, legal assistance, and housing. Such services are necessary for recovery and can also act as inducements to participate in treatment. Although there is certainly room for both the criminal justice and treatment systems to provide ancillary services to offender-clients during and after treatment, it is recommended that the treatment provider provide or arrange for these services when possible.

Some probation or parole officers are responsible for managing all aspects of the service delivery plan. This may present conflicts for treatment professionals who are accustomed to taking responsibility for the client's full treatment plan. While the situation and the division of responsibilities vary across jurisdictions, probation officers in many areas have caseloads that are too large to coordinate these services effectively. Treatment programs are typically part of a larger network of human service providers and may be better positioned to access services for offender-clients.

Some have argued, moreover, that the client will be less confused if the surveillance and supervision function is clearly separated from the helping role of providing ancillary services. However, some probation, parole, and other community corrections officers do not want to limit themselves or their responsibilities to law enforcement, preferring to define themselves as

helpers as well. Cooperation and collaboration will be more fruitful if that role is recognized and those officers are encouraged to take on some of that responsibility.

## **Barriers to Engaging the Offender-Client in Treatment**

The offender-client comes to treatment with many internal barriers and obstacles that can inhibit treatment effectiveness and the client's progress. The characteristics of offenders that serve most often as barriers to treatment include:

- A history of failure
- Alienation from the social structures and the governmental agencies that typically and repeatedly have a major impact on them
- A sense of hopelessness that anything can make a difference in their lives
- Cynicism about the opportunities offered by social service agencies
- A tendency to manipulate systems that affect them
- Unrealistic expectations of treatment,
- A culturally supported belief that treatment is for people who are weak
- The perception that treatment is punishment or an additional sanction.

### **Experience With Failure**

Offender-clients typically have had more substantial experience with failure and less experience with success than the voluntary treatment-seeking population. Therefore, orienting the offender client toward small accomplishments in the treatment process is an important task, particularly during the early stages of treatment. Treatment programs and corrections agencies should work together to build in small success opportunities for clients so that they gain confidence as they progress through treatment and complete supervision requirements. These can include making and keeping an appointment, having a negative urine drug test, or completing a homework assignment. Well-formulated intermediate sanctions programs will build in small structured steps that clients can take successfully with relative ease.

### **Alienation, Hopelessness, and Cynicism**

As indicated above, offender-clients bring to treatment both the classic patterns of addiction behavior and the particular experiences of having reached the point of engaging in criminally deviant and destructive (to themselves or others) behavior to maintain their addiction. Their status as both addicts and offenders who have been forced into treatment and who may yet face severe penalties for their actions may enhance their sense of having little to hope for and their belief that recovery is not worth the hard work needed to achieve it. They may believe that they are so far down that the treatment will not work for them.

Some offender-clients do not perceive their AOD abuse as a problem or its treatment as a priority. In the face of all the other problems that they may have, they are often more focused on collateral needs such as those for housing, medical care, and employment.

Even if offender-clients have a desire to strive for recovery, their life experiences may have led them to believe that treatment providers' promises are meaningless and will not be fulfilled. The typical offender-client has little to show for years spent in school, in training programs, and probably in social service programs. Frequent past contacts with law enforcement and other criminal justice agencies that resulted in few if any consequences may lead the offender-client to believe that this experience will be like all the others: Nothing that is said is meant, and neither threats nor promises will be kept.

AOD treatment and criminal justice professionals must endeavor to promote client receptivity and engagement with the treatment and recovery processes. To accomplish this engagement, both groups must work to help the offender-client overcome alienation, hopelessness, and cynicism. In the same way that treatment and intermediate sanctions programs must build in small steps to make success possible, they must also ensure that promises are kept; that consequences of behavior, both positive and negative, are delivered quickly and consistently; and that the programs promote a sense of self-worth among the offender-clients. Such goals may make it necessary to adjust the environment and change attitudes of program staff.

---

*In the same way that treatment and intermediate sanctions programs must build in small steps to make success possible, they must also ensure that promises are kept; that consequences of behavior, both positive and negative, are delivered quickly and consistently; and that the programs promote a sense of self-worth among offender clients.*

---

Treatment professionals should be willing to look at the treatment settings to make the physical environment more appealing to clients. A clean, well-cared-for, attractive facility connotes respect for everyone in it and for what goes on there. AOD treatment professionals should encourage staff attitudes that also convey respect for clients. For example, the manner in which clients are addressed should convey respect; clients should be asked rather than told what their needs are and how they will be met. In this way, the offender-client and the treatment provider are more likely to function as a team to promote the client's recovery.

### **Treatment as Punishment**

Treatment for the offender is usually ordered within the context of a criminal proceeding, and, in the case of intermediate sanctions, within a sentencing proceeding. Thus, the justice system usually communicates to the offender that treatment is punishment. Indeed, in this context treatment is *not* voluntary and *is* part of a sanction. However, the sanction is intended to benefit the offender. The major therapeutic challenge to the treatment system is to address offenders' likely resentment that treatment has been imposed on them.

Theoretically, the criminal justice system dispenses punishment to offenders and the treatment system offers help to AOD abusers. When the two systems work together, the punishment and assistance elements become enmeshed in practice and in the offender's mind. In the context of

intermediate sanctions, no meaningful distinction exists between treatment as a punitive and a nonpunitive measure.

Offender-clients need assistance to clarify and resolve this conflict between the criminal justice sanction and AOD treatment. Once the offender-client is involved in AOD abuse treatment, treatment professionals, with support from the probation or parole officer, should help the client refocus on the goals of treatment and recovery. To benefit from treatment, the offender needs to move beyond the fact that it is involuntary and to understand that treatment represents an opportunity to help himself or herself.

The goals of treatment and recovery are likely to vary somewhat among treatment modalities and groups of offender clients but, in general, treatment professionals need to:

- Help the offender-client develop the motivation to create an AOD- and crime-free orientation
- Help the offender-client solve the ancillary but still pressing problems associated with AOD abuse, which are often a mix of psychosocial, medical, financial, and entitlement problems.

### **Manipulation of the System**

Addicted individuals typically manipulate the people and institutions that surround them. Offender-addicts generally have been engaged in manipulative behavior for a long time and with many systems.

The treatment and criminal justice systems must accept responsibility for not permitting or facilitating manipulation, either within their own system or through giving different or opposing signals to offender-clients. Good cross-system case management is critical to dealing with manipulation. Clear, consistent, and uniform messages and responses from the criminal justice and treatment systems are one way for the two systems to promote recovery and avoid being used against one another.

For similar reasons, it is crucial to establish and enforce effective sanctions for infractions in treatment so that offender-clients know that their behavior will have consequences. Offenders communicate among themselves, and if the word is out on the street that the treatment program does not deal seriously with rule-breaking, the program will be faced with endless efforts to manipulate its rules.

### **Unrealistic Expectations of Treatment**

Offender-clients need to be educated about the treatment process and the expectations for their active role in treatment. They need to be taught that treatment will not take care of all of their problems, and that passive involvement in treatment will not produce results.

### **Engaging the Offender-Client In Treatment**

In much the same way that the criminal justice and treatment systems must collaborate to provide treatment services to offender-clients, the collaborative system must forge another

relationship, one that makes the offender-client a full participant in the process of his or her own treatment and recovery.

There are several key requirements for bringing the offender-client into a partnership role:

- Fully inform clients. Fully disclose to them the expectations of both systems and the repercussions if expectations are not met. Clarify what treatment is and is not.
- Create and develop a therapeutic alliance with clients to help set recovery goals that are realistic and meaningful to them.
- Provide immediate and appropriate responses to positive and negative behavior.
- Follow through on commitments to clients.
- Empower clients to participate in the recovery process.
- Treat clients with respect.
- Acknowledge and attempt to address clients' other problems (which may result from or be independent of AOD abuse problems.)
- Ensure that representatives of the two systems speak with a single voice on critical issues and that system responses to key incidents are jointly supported.
- Create positive and negative incentives for clients.

### The Client Agreement

From the outset, staff in the two systems must present a single message about their common expectations to the offender-client, as well as good, clear information that is as consistent as possible. One way to achieve both of those objectives is through the use of a client agreement.

The client agreement addresses issues similar to those addressed by the agreement between the treatment and criminal justice systems. The systems agreement defines the intermediate sanctions program, specifies its goals, and indicates each system's responsibilities to the other and for services. The client agreement describes the sanction, the treatment program, and the expectations and responsibilities that the intermediate sanctions program places on the offender-client. Clients are expected to sign this agreement.

The specific information that it is crucial for clients to know may vary according to the jurisdiction, the type of sentence, and the nature of the crime. The general issues to be covered in the client agreement are shown in [Exhibit 5-2](#).

The client agreement might also include information about the nature of AOD abuse and treatment and describe expectations of treatment participants. That information might include:

- The outcomes that can be expected from treatment
- The limitations of treatment
- The demands that treatment and recovery place on the participant
- A description of recovery as a process
- Information about relapse and related behaviors.

The offender-client's signing of this agreement should be considered and treated as a ceremonious affirmation of his or her responsibility and participation. It is the first step in the process of recovery.

The key elements of this agreement should be summarized in simple language, particularly those that describe behaviors that necessitate criminal justice sanctions. Accordingly, the client agreement should reference any criminal justice system waivers and consents that are applicable to offender-clients.

### **Information About Treatment**

Informing clients about treatment is essential not only for engaging clients in the process, but also for keeping them actively involved. An especially important part of that information is the pivotal role that they themselves play; client participation and input are critical aspects of the treatment plan. Clients should be told that this is their treatment, and that they are expected to participate in the process. That the treatment is the client's is one of the primary tenets of voluntary treatment. Because offender-clients are not voluntary participants, the treatment system may need to find ways to "reframe" its strategy with this group.

A brief document describing the nature and components of AOD abuse treatment can help prepare clients psychologically. In addition to giving the document to clients, the information should be read to them as well. The document should define the goals and objectives of treatment, describe the process in which clients are about to participate, and describe what outcomes they can expect. For offender-clients, it should also include expectations of participation in treatment as a component of an intermediate sanction.

A number of States require treatment programs to provide this kind of information both in writing and orally to potential clients as part of obtaining informed consent from clients for treatment.

Clients should also be educated about the differences between "doing time" and participating in treatment. Treatment may be more difficult than doing time, because the client has to work and participate actively in creating behavior change. The treatment professionals should acknowledge that treatment is hard work and help the offender-client define the possible payoffs for the effort.

---

*Treatment may be more difficult than doing time, because the client has to actively work and participate in creating behavior change.*

---

### **The Therapeutic Alliance**

Treatment is dependent on the therapeutic alliance between the offender-client and the counselor. Bonds must be created early, or the potential for losing the client increases greatly. The client

should feel some personal connection with the processes of entry into and participation in treatment. Adversarial relationships with clients are counterproductive.

Treatment providers may find it easier to establish this bond if they can identify and focus on issues important to the client, instead of on external or system expectations and requirements. Such an approach requires framing recovery and the expected behavior changes in a context that is both pragmatic and beneficial to the client. The alliance will also be more likely if treatment professionals do not impose on clients the system's idea of what their problems are; clients must identify their needs and the problems that they want solved. The job of the treatment team and the function of the therapeutic alliance is to help clients identify and gain access to solutions for all of their problems.

Culturally sensitive and appropriate interactions with the client are necessary for the alliance. With individuals from some cultural groups, for example, the extended family should be involved in supporting the treatment plan. With those from other groups, the treatment provider will have to accept the fact that the client does not believe that the provider can understand his or her needs and problems.

### **Relapse and Relapse Prevention**

The rate of AOD relapse is high among offender-clients. Relapse prevention information and activities must be included from the beginning and throughout treatment. These clients need to learn relapse prevention skills such as refusing AODs, and identifying and managing the triggers of craving. When relapse occurs, clients must be helped to understand it as part of the recovery process rather than as a personal failure. They can pick up and go on to success.

In negotiating the intersystem agreement, treatment and criminal justice professionals need to address the issue of the likely relapse of offender-clients. Both systems should support sanctions along the treatment continuum so that relapse is not punished as if it were an additional criminal offense. Criminal justice decisionmakers at all levels should be reminded that relapse is a characteristic feature of AOD abuse that needs to be anticipated, prevented, and addressed.

### **Positive Incentives**

To engage the offender-client in the treatment process, it is most helpful to make use of all available positive incentives for treatment. These are varied and will depend, naturally, on the values, interests, and needs of the particular group of clients.

To overcome offender-clients' sense of hopelessness, treatment providers and criminal justice system agencies should provide contacts with peers engaged successfully in the therapeutic process. Such exposure to models of success has been demonstrated to influence individual success in treatment. In the context of intermediate sanctions, both systems need to realize that successful peers are often lacking in nonresidential treatment environments. In outpatient settings, therefore, different types of role models for offender-clients should be identified and made available.

Some courts and corrections agencies have had success with group sessions, either in a drug court setting, group supervision sessions, or in separate group court appearances for AOD cases, in which current and former clients who are doing well appear and are congratulated by the judge or agency supervisor. These clients may be commended for having accomplished even small, but important, goals. Such an approach is similar to developing peer leadership in residential treatment programs. Efforts like these help focus criminal justice decisionmakers on evaluating and rewarding of offender clients for small steps accomplished along the way, rather than for total recovery or rehabilitation. These strategies also help keep offender-clients involved and engaged in treatment and compliant with the intermediate sanction.

Treatment programs often provide other services that can serve as incentives for offender-clients to engage and participate in the program. Those services can be as basic as a safe, secure, and comfortable place to live (in residential programs); medical care; child care; or referrals for free food (in nonresidential programs). Treatment professionals should not hesitate to use these other services to sell the client on treatment. Not only do they help engage clients, they also meet some of the offender-client's critical human needs.

In some cases, successful completion of a treatment program can be used as an incentive to secure a change in the overall sanction facing the offender-client. Such a change might include less intrusive supervision or a less restrictive curfew, a reduction in the duration of supervision, or a reduction in a community service obligation.

### **Consequences of Negative Behavior**

As has already been indicated, there are many important reasons for providing and enforcing clear, consistent consequences for failure to comply with treatment requirements. For offender-clients, it is also important that the consequences be provided within the treatment continuum before the criminal justice system responds. (These are covered in more detail in [Chapter 6](#), but might include requiring more frequent attendance at Alcoholics Anonymous meetings or more frequent urinalysis.) Every treatment problem encountered should not engender a response from the criminal justice system. The two systems have the challenge of developing sanctions along the treatment continuum and determining when criminal justice intervention is appropriate.

---

*The two systems have the challenge of developing sanctions along the treatment continuum and determining when criminal justice intervention is appropriate.*

---

The supervising corrections agency typically has considerable discretion in this regard. In some jurisdictions, the corrections officers themselves have substantial discretion in making violation decisions. Such discretion can cause problems if the parole or probation officers apply different standards and the treatment program is working with the clients of many different officers. In the interests of consistency and fairness across the two systems, a set of basic guidelines within which all agencies and officers will operate should be developed. Such guidelines might specify

categories of behavior and a range of responses for each category. If both systems focus on promoting desired behavior and specific outcomes for each offender-client, then some discretion must be available to both the treatment providers and the criminal justice practitioners. General guidelines can permit both consistency across cases and flexibility in individual cases. [Exhibits 5-3](#) describes incentives for treatment and consequences of negative behavior.

### **Establishing Length of Treatment**

When directing offender-clients to treatment, it is essential to realize that different types of AOD abusers require different durations and intensities of treatment. *AOD abuse treatment needs should be determined by the client's category of AOD abuse rather than by offender type.* Clients with a chronic AOD abuse history have the most pressing and extensive treatment needs. Offenders who use drugs casually will not need the same level of treatment.

Generally, there are four categories of AOD abusers among the criminal justice population:

- Casual AOD abusers only marginally involved in AOD abuse or crime
- Addicted offenders with an established pattern of abuse or dependence
- Antisocial offenders for whom AOD abuse is symptomatic of a criminal lifestyle and of criminal values
- Mentally ill, chemically dependent offenders.

The congruence of treatment duration and level with the sanction imposed is of great concern to both systems. On the one hand, the criminal justice system is required to impose a sanction whose length and intrusiveness is limited, if not determined, by factors related to the seriousness of the offense and the offender's criminal history. On the other hand, a sanction that includes a treatment requirement that is not related to the assessed AOD treatment needs of the offender may be a waste of resources.

With adequate information about each system available to the other, and effective communication between the two, the criminal justice and treatment systems can devise strategies for ensuring congruence between treatment and the sanction imposed. This approach must begin with a realistic set of expectations on each side. For example, criminal justice decisionmakers need to realize that recovery is not possible when they order an offender who needs intensive, long-term treatment to an outpatient treatment program for 3 months. In that situation, however, it may be realistic to expect the offender to become treatment ready, that is, prepared for and wanting treatment.

For its part, the treatment system may need to intensify its services and prepare for the shorter-term sentences of many offender-clients. In addition to focusing on treatment readiness for such clients, treatment providers may have to concentrate on strategies to attract the client toward longer-term, voluntary treatment services, while criminal justice system decisionmakers support increased funding and availability of such services.

Criminal justice system decisionmakers must also become educated about the pitfalls of the opposite situation: the offender who is assessed as a casual AOD user, but who is ordered by the

court to a long-term residential program because the court wants him or her in a structured environment away from the street. Such an offender-client is bound to become frustrated and difficult for the treatment program to manage, and may fail to complete the sanction (and thus be classified as an even more serious offender by the criminal justice system). To avoid these cases, treatment providers must be active in reaching out to and educating judges and other decisionmakers in the justice system.

### ***Understanding the Stages of the Recovery Process***

Defining and explaining the steps in the recovery process are important parts of educating the criminal justice system about the problems offender-clients face on the road to recovery, and about realistic expectations at various stages of treatment. The typology of the stages of treatment outlined below, although helpful, is very general; individual AOD abusers in treatment show substantial variation. Recovering AOD abusers cycle through these phases, perhaps several times, and relapse frequently occurs.

#### ***First Stage: Early Recovery Period***

In the first several months, the objective is to engage offender-clients in the process of treatment. An initial treatment goal is their acknowledgement of the profound problems related to their abuse of AODs. An additional treatment goal includes recognizing the presence and severity of the AOD abuse problem and their corresponding need for help.

This stage is marked by substantial fluctuations in client progress; the client's commitment to treatment usually vacillates. Ideally, the client reaches the point of understanding that treatment is important and makes a commitment to it. Attempts to bargain with the treatment staff are to be expected as the client explores and tests the system. A number of positive urine tests usually occur during this early phase.

During this early recovery period, with its erratic\_if predictable\_behavior, primary responsibility for the monitoring of offender-clients is probably best left to treatment providers, who are trained to handle clients' testing and exploring of the recovery process.

#### ***Second Stage: Re-evaluation of Lifestyle***

The second stage begins when the client becomes engaged in the treatment process. It is a period of significant growth for AOD abuse treatment clients. Clients generally come to terms with the other major problems that are related to or have been affected by AOD use, such as relationships and value systems.

Most of the work of treatment is accomplished during this phase. Clients begin to respond positively to treatment and behave according to the treatment program's requirements and goals. The duration of this phase varies significantly among individuals\_from a few months to a year or more.

### ***Final Stage: Reintegration***

In the final stage, clients begin to take responsibility for themselves. If they are still in a treatment setting, they begin to take responsibility for their leadership role with new people entering the treatment environment. Clients begin their reentry into the world or refocus on the ordinary business of life outside of treatment. The treatment focus is on maintenance of recovery after treatment and on assisting clients with the tasks of reentry or reengagement with work, family, and community. Again, the duration of this phase varies among individuals.

### ***Implications of Treatment Stages for Intermediate Sanctions***

Treatment providers typically want to focus treatment resources during the early recovery phase to help ensure that the client is drawn into and thoroughly engaged in the recovery process. Treatment programs also emphasize rules at this stage, where behavior problems and infractions usually peak. Expectations of such problems must be factored into the treatment-intermediate sanctions plan, which should incorporate substantial monitoring and drug testing in the early stage. At this stage, the treatment system focuses on enhancing offenders' motivation and commitment to treatment to help clients develop accountability for their behavior in the treatment program.

Resistance to treatment and dropping out of the program are highest in the early stage. Relapse, however, is part of the recovery process and may be anticipated at any point. The treatment provider must take the lead in developing treatment sanctions for reasonable occurrences of relapse, though the imposition of sanctions in individual cases should be made jointly with the criminal justice system practitioner involved.

### ***Determining Treatment Needs: Screening and Assessment***

Assessment for AOD abuse treatment needs is a several-tiered process that all clients must go through to be placed appropriately. This subject is covered in detail in another TIP, *Screening and Assessment for AOD Abuse Among Adults in the Criminal Justice System*, and will be discussed only briefly here.

#### ***Screening***

This initial step by the criminal justice system should screen offenders for two items relative to treatment within intermediate sanctions: 1) likely AOD abuse and 2) eligibility for the jurisdiction's intermediate sanctions programs as designed.

Screening should occur as early in the criminal justice process as possible, prior to sentencing if that is feasible. Screening might be described as a rough cut, the first step in deciding whether an offender is at all suitable for intermediate sanctions and AOD treatment. Screening can determine whether an offender meets the agreed-on eligibility requirements and eliminate those that do not. Eligibility requirements typically cover both the need for AOD abuse treatment and the severity level of sanctions required to make a treatment referral. The screening process

gathers information about the offender and the offense necessary to make a decision about whether he or she should be sentenced to a particular sanction.

---

*The screening process gathers information about the offender and the offense necessary to make a decision about whether he or she should be sentenced to a particular sanction.*

---

Screening for intermediate sanctions must employ the criteria established by a collaborative planning group representing both systems. Certain categories of offenders constitute the target group or groups, that is, those for whom the intermediate sanctions were developed. For example, the screening instrument might consider:

- The offender's previous criminal history
- The offender's level of risk to public safety
- The offender's performance in any previous sanctions or periods of pretrial supervision
- The offender's previous experience with treatment
- The specific nature of the offender's crime that might indicate a more or less appropriate sanction (for example, sentencing a drug dealer to home detention may do nothing to stop his or her dealing activities).

Determining who meets these criteria should be as objective a process as possible. For example, an objective risk or risk-needs assessment instrument is one way to measure the public safety risk represented by offenders, and the severity of their individual needs in a variety of psychosocial areas. This correctional assessment may form the basis of a recommendation about the type and duration of the sanction. A risk-needs assessment can be a useful part of any presentence investigation.

The nature of the offender's AOD involvement, either from a self-report or from a toxicology screen, is also a necessary component of this piece of the process. The intermediate sanction referral must be matched to necessary treatment; for example, if an offender needs residential AOD abuse treatment and the severity of the offense permits that level of intrusion, then home confinement does not make sense as an intermediate sanction option.

Each jurisdiction must determine who performs the initial screen -- that is, who is the first-level gatekeeper. Usually, the judge makes the decision or agrees to the use of intermediate sanctions, but there is more flexibility in determining who gathers the information on which the decision is based. It is usually collected by the probation agency or court assessment unit, or an independent agency.

When screening suggests that an offender may have an AOD problem, the offender should be clinically assessed by a treatment professional.

Screening for communicable diseases (HIV, TB, and sexually transmitted diseases) also needs to be conducted or arranged for at this time. Actual counseling and testing may be done at any approved public health site as discussed earlier.

## **Assessment**

Assessment is the process of determining the nature of the offender-client's AOD abuse and placing him or her in the appropriate treatment modality (or recommending such placement). The criminal justice system also conducts assessments of various sorts, but in the context of AOD abuse treatment, assessment is a comprehensive, clinical addictions assessment.

---

*Assessment is the process of determining the nature of the offender-client's AOD abuse and placing him or her in the appropriate treatment modality (or recommending such placement).*

---

One of the problems with securing proper treatment for the offender-client is that criminal justice screening often substitutes for a complete clinical assessment. Clinical assessment is absolutely necessary. Criminal justice screenings or "quick and dirty" assessments are incomplete and insufficient for matching alcohol and other drug abusers to the right level of treatment.

### ***Who Should Do the AOD Assessments?***

It is recommended that the AOD assessment of offender-clients be conducted by a treatment professional. If it is not feasible to involve treatment providers at this stage of presentence recommendations, then the criminal justice system should have its own trained addictions personnel to conduct the assessments.

### ***Who Should Be Assessed?***

Although it is very difficult to determine the exact rate of AOD abuse (as opposed to AOD use) among the offender population, the National Institute of Justice's Drug Use Forecasting system reported that in 1990, more than 50 percent of a sample of arrestees in 24 urban areas tested positive for at least one drug at the time of their arrest. Anecdotal reports by criminal justice practitioners put the AOD abuse figure among offenders at 70-80 percent. In any case, treatment resources simply do not exist that are sufficient to handle either number. Accordingly, it is not recommended that every potential treatment candidate be routed for an assessment.

In jurisdictions struggling to make the best use of existing resources, or planning their best use, policymakers may want to consider sending for clinical assessment only offenders who meet criteria for intermediate sanctions programs. (On the other hand, an AOD abuse *screening* of every offender would provide extremely useful data on treatment resource needs for this population in a jurisdiction.)

The collaborative system needs two funnels: one for offenders whose sentence will not include treatment, but who should be referred for voluntary treatment; and another for those who are remanded into custody or who receive an intermediate sanction.

### ***When Should Assessments Be Performed?***

If the criminal justice system screening establishes that the offender is likely to have an AOD abuse problem and meets the criteria for intermediate sanctions, then the clinical assessment should take place as soon as possible -- at the very latest, after a plea or trial.

Certainly, the criminal justice system is taxed, and its processes are often overloaded and rushed. The court must support the necessity and value of conducting good clinical assessments of eligible offenders for the system to accommodate this additional step in the sentencing process and the additional expense.

### ***Linking the Assessment Process to the Treatment Process***

The way the client responds to treatment is partly a function of how he or she initially encounters treatment services. Accordingly, when conducting the clinical assessment, treatment staff should be attentive to their interactions with the client and should try to "invite" him or her into the treatment process. If, as recommended above, treatment staff conduct the assessment, clinical control can be exerted over the introduction to treatment and the client's perception of and reaction to the process. Treatment staff can also question the client with protection for the confidentiality of the information provided. (Please refer to [Chapter 7](#) of this document for a fuller treatment of this topic.)

### ***Limiting Repetitive Questioning of Offender-Clients***

It has been recommended that criminal justice screening be limited to identifying likely AOD abuse among offenders who meet the criteria for the jurisdiction's intermediate sanctions, and directing those so identified to a treatment professional for a thorough assessment. The treatment professional should then provide the assessment results to the criminal justice system. One reason for placing the assessment responsibility with a treatment provider is to ensure that a thorough clinical assessment is only conducted once, and that the client does not have to answer evaluative, personal questions over and over.

However, basic demographic and personal history information about the offender is needed by agencies of both the criminal justice and the treatment systems. Each item of this information should be collected only once, with each office or agency adding only new data items. This cumulative information sheet should follow the offender-client and be shared among criminal justice and treatment agencies.

The redundancy typically exhibited in the collection of basic information about the offender and the frequent repetition of the same questions are obstacles to establishing positive relationships with the client, as well as a misuse of staff time and resources in both systems. Early clinical participation with the client is seen as essential by treatment professionals, and having this basic

demographic information already available would free time for the treatment staff to begin developing the clinical relationship via the comprehensive AOD abuse assessment.

Policymakers from the two systems need to agree that one point for the integration of the two systems is information collection. The collaborative system should agree on the nature of the information collected, where it will be collected, and how it will be transmitted between agencies.

To protect the integrity of the information collected, planners of the data collection process should carefully determine where in the criminal justice system the data sheet originates. Because information will be collected only once, it becomes even more imperative that it be accurate. It would make sense to assign this responsibility to a stage of the intake process in which there is less pressure to complete the work quickly.

### **Placement in a Treatment Program: The Lack of Treatment Capacity**

Despite concerted joint efforts by the criminal justice and treatment systems to develop an excellent screening and assessment process, both systems will still be faced with the problem of inadequate treatment resources and the reality of AOD treatment waiting lists. Too often there are more offenders who fit the criteria for placement than there are slots available. Although the principle of immediate access to treatment is theoretically sound, the practical reality is that it is not always possible. However, if waiting lists seem unmanageably long and it is apparent that some clients will never get into programs they have been recommended for, in the absence of increased resources, program entrance criteria may need to be defined more narrowly.

---

*Although the principle of immediate access to treatment is theoretically sound, the practical reality is that it is not always possible.*

---

All other things being equal, waiting lists should be run on a first-come, first-served basis. Waiting list programming should be established that provides pretreatment services that use minimal resources to keep clients involved until treatment slots become available. The intermediate sanctions programs themselves may also have to make adjustments because of the lack of available treatment resources; for example, a day reporting program that requires outpatient treatment may have to be redesigned to include waiting-list clients.

### **Case Management**

Case management is the process of linking the offender with appropriate resources; tracking the offender's participation and progress in the referred programs; reporting this information to the appropriate supervising authority and, when requested, to the court; and monitoring conditions imposed by the court.

Case management is an essential ingredient of successful intermediate sanctions programs. Such programs are really only additional tools to provide the services, support, and accountability to offenders in the community that together constitute the heart of good case management. When intermediate sanctions and AOD treatment are combined, the necessity of case management becomes even greater.

### The Functions of Case Management

Case management for offender-clients should provide the following functions:<sup>1</sup>

- Assessment: determining the client's strengths, weaknesses, and needs; evaluating the client's ability to remain crime free and drug free ensuring development of the overall case plan
- Planning: for treatment services and the fulfillment of criminal justice obligations, such as meeting community service and restitution requirements and maintaining regular contacts with the probation officer or other criminal justice officials
- Brokering treatment and other services and assuring continuity as the client moves along the criminal justice and treatment continuums
- Monitoring and reporting progress
- Client support: identifying problems and advocating for the client with legal, treatment, social service, and medical systems in response to client's needs
- Monitoring urinalysis, breath analysis, or other chemical testing for AOD use.

Case management is the point at which the implementation of the criminal justice and treatment systems' collaboration is tested. Successful, joint case management -- whether actually done by one agency or both -- rests on the foundation of the two agreements described earlier. The *client agreement* lays out the content of the sanctions, the treatment protocol, the offender-client's obligations, and the repercussions of infractions or failure to comply with the sanction. This agreement represents a contract between the two systems and the offender. The client agreement becomes the guiding document for managing offender-clients through the intermediate sanctions and treatment programs.

The second *agreement, between the two systems*, outlines how the criminal justice system and the treatment system will manage the caseload of offender-clients in the jurisdiction. This agreement defines some of the overall parameters that are relevant to the collaborative system in the context of case management.

### Who Does the Case Management?

There can be a single case manager, or there may be two -- one from the treatment system and one from the criminal justice system. If there are two case managers, they must work in tandem and make sure that efforts are coordinated. Working together, they can encourage a multidisciplinary approach that takes advantage of a wide range of treatment and rehabilitation options.

If there is to be only one case manager, that function should probably be within the treatment system, even though that system may become overloaded with increasing numbers of offender-

clients. Furthermore, if resources permit, it is recommended that the person who does the specific AOD counseling not be the same person who is responsible for the court supervision part of case management.

Jurisdictions vary, however, and some probation and parole officers define their roles as resource providers and resource brokers. If caseloads permit, these officers can serve equally well as case managers or co-managers.

### **Impediments to Good Case Management of Offender-Clients**

#### ***Volume***

The number of correctional field officers has not kept up with the growth in probation and parole cases under supervision over the last 15 years. As a result, the National Institute of Justice reported that the average probation caseload in the United States is now 120 per officer, and in some areas that ratio is much higher. Such caseload size represents a major impediment to the ability of criminal justice practitioners to either carry out effective case management or participate meaningfully with treatment personnel in managing cases.

Because new and increased resources have been dedicated to law enforcement and prosecution in drug cases, much of the increased caseload volume has come in that area. With more cases, and no corresponding increase in treatment capacity for offenders, criminal justice practitioners and decisionmakers have difficulty focusing on individual cases. There are too many of them and too few resources to make intervention seem worthwhile.

Policymakers from both systems must struggle to overcome the cynicism and hopelessness that are unfortunately as common among probation and parole officers in this regard as among clients. While additional resources, both in officer positions and treatment capacity, will be necessary, enhanced attention and effort by agencies and policymakers from both systems will also be helpful.

#### ***Confidentiality***

Because treatment programs and services are rooted in the traditional client-counselor relationship, the treatment system is particularly attuned to issues of confidentiality in sharing and transmitting information to the criminal justice authorities. Treatment professionals are bound not only by their own code of ethics, but also by Federal regulations regarding the privacy rights of clients in AOD treatment. (See [Chapter 7](#) of this TIP for a full discussion of those regulations.) Criminal justice practitioners, on the other hand, expect that the court and its officers have the right to all information about the offender. Their concern about protecting public safety may make them suspicious when any information seems to be withheld from them. This divergence in attitudes between the treatment and the criminal justice systems can be a source of some friction in handling offender-client cases.

In the intermediate sanctions process, the confidentiality requirements of each system must be examined carefully. As the two systems design and develop the collaborative agreement, the

issue of confidentiality should be resolved by identifying particular types of information that must be communicated to the criminal justice system and the infractions that can be handled with treatment sanctions both with and without notification of the criminal justice system.

### ***Desired Outcomes of Treatment***

The treatment and criminal justice systems differ in regard to the treatment outcomes that they desire. The differences are a potential source of conflict. On the one hand, treatment personnel are typically more tolerant than criminal justice practitioners of the relapses and intermittent failures of the offender in recovery. On the other, their ultimate expectation for that offender is doubtlessly higher: They want to see a sober client whose life is free of AODs and free of the lifestyle that is often part of AOD abuse. Criminal justice practitioners may wish for such an outcome for individual offenders, but they would be happy with less, that is, with the offender's AOD abuse under enough control for the offender to be able to remain crime-free and meet the other requirements of the sentence or parole. The treatment provider wants abstinence and full recovery; the criminal justice practitioner hopes for compliance with the law and conditions.

---

*The treatment provider wants abstinence and full recovery; the criminal justice practitioner hopes for compliance with the law and conditions.*

---

Although these differences are subtle, the potential exists for conflicts between the two systems over the level of supervision, expectations about services, and the nature of behavioral requirements.

### ***Payment for Treatment Services***

Treatment programs typically absorb most of the costs incurred by criminal justice clients, even when the clients are ordered into the program by a judge or parole board. Issues relating to payment are a formidable impediment to developing coordinated care for offender-clients. Clearly, there is a need for greater resources for treatment generally, but there is also a specific need for the criminal justice system to generate additional resources for offender-clients.

A possible remedy to this dilemma is to divert funds not used for planned jail beds into treatment for offenders as those offenders are diverted from jail into treatment. These funds, however, may not be available for use to purchase treatment services. Another potential source of funds are those generated by the forfeiture cases brought by prosecutors in drug cases. The two systems also need to collaborate and apply jointly for available State and Federal funds and to advocate with a unified voice for the availability of increased funding for treatment.

The argument to be made for adequate funding of treatment for offenders, particularly offenders who meet the criteria for intermediate sanctions, is really a quite powerful one. Resources are far better spent on confronting and treating the underlying source of criminality than on either just

jailing AOD-abusing offenders or simply restricting their movement. Adequate treatment is more likely to end their criminality.

Meanwhile, payment responsibility for treatment for criminal justice clients needs to be clearly indicated in the system agreement. The parties may want to add to the agreement their plan for and commitment to seeking additional resources.

## Ethical Issues

Combining AOD treatment with intermediate sanctions raises two sets of ethical issues. The first has to do with dedicating some portion of scarce and valuable treatment resources to those who have been convicted of crimes. The second concerns the difficulties of using the apparatus of the criminal justice system to coerce participation in treatment, a supposedly beneficial activity.

### The Use of Scarce Resources

If AOD abuse treatment were in unlimited supply, providing such treatment to offenders would not be an issue. Unfortunately, this is not the case, and it may appear that the criminal justice system and intermediate sanctions programs are taking services away from people who are innocent of crime (other than possession and use of illicit drugs or prescription drugs obtained fraudulently -- "innocent" is a relative term in this arena) by directing a large number of criminal justice offenders into treatment. In some jurisdictions there are waiting lists for publicly funded treatment programs. If treatment resources are indeed quite scarce in a community and most services for offender-clients are provided outside the criminal justice system, then the appearance of taking services away from people who have not committed crimes may be reality. This raises a very significant ethical question: Given limited treatment slots, does someone have to commit a crime to get one?

---

*Given limited treatment slots, does someone have to commit a crime to get one?*

---

Criminal justice and treatment policymakers must confront this issue together. They should collaborate on common efforts to secure increased treatment capacity and funding. To create this increased capacity, the two systems may need to pool and reallocate their existing resources and coordinate funding requests.

Even with increased capacity, there will probably never be enough treatment for everyone who needs it. However, solid reasons remain for giving criminal justice clients some priority when existing treatment resources are allocated.

- Criminal justice clients present a high risk for relapse and reoffending.
- These clients typically would not otherwise receive treatment.

- Studies suggest that offender-clients whose treatment is coerced have better retention rates in treatment than clients who are not coerced. Accordingly, the offender-client should be viewed as a potentially more responsive client.

Ideally, treatment capacity projections should include estimates for criminal justice clients so that offenders do not take treatment slots from voluntary clients. In any case, the criminal justice system's policymakers must be aware of the impact of their population on a limited treatment system.

### **Inappropriate Use of Treatment and Intermediate Sanctions**

One of the chief difficulties in combining intermediate sanctions and AOD abuse treatment is related to the fundamental divergence in purpose between the two: Intermediate sanctions are one set of tools used by the criminal justice system to enforce the will of the larger society on its members. The criminal justice system makes use of the power of the State to inflict unpleasantness (deprivation of liberty and property) when individuals refuse to abide by society's behavioral norms. In fact, this reality is nowhere more evident than in the area of drug use and the definition of some substances (marijuana, for example), but not others (alcohol or tobacco), as illicit and their use as punishable by sanctions of all sorts. The criminal justice system is based on the power of the State to deprive individuals of liberty and property and on the consequent fear of citizens of violating the law.

AOD abuse treatment exists to help individuals become more fully realized, self-controlling persons. Its chief aim is individual empowerment through recovery, rehabilitation, and sobriety. Although treatment also emphasizes client accountability and respect for rules, the purpose is benign *for the individual*, that is, such an emphasis is aimed at helping the client achieve self-control.

The difficulty in combining these very different approaches -- punishment and self-realization -- and purposes is that as a society we are attempting to use the power of the State (as expressed by the justice system) to force what is supposed to be a beneficial and empowering activity -- treatment -- on the individual. By coercing treatment, we assume that our judgment of what is in the best interests of the individual surpasses his or her own judgment. We submerge the interests of the individual to those of the larger community and require the individual to change.

Because treatment is considered a benefit, a good thing for the client (even a gift), it is easy to overlook the element of coercion that is present when the criminal justice system is involved. It becomes easy over time to want to use even more coercion to force more treatment -- because it is all for the individual's own good. This rather appealing notion tends to overlook the consequences to the involuntary client when he or she cannot achieve recovery, or perhaps even when he or she simply goes through the inevitable process of denial, resistance, and relapse that characterize the recovery process.

The descriptions that follow explore dimensions of ethical conflicts that can arise from combining treatment and intermediate sanctions. From the criminal justice perspective, the

ethical issues usually derive from violations of any of several basic principles and values of criminal justice:

- The government will not intrude on the individual's life unless the individual breaks a law that has been publicly enacted.
- The punishment ordered in response to the law-breaking will be proportional to the seriousness of the offense.
- When the government does intervene in a person's life, it will seek the least intrusive alternative.

### *[Net-Widening and Net-Tightening](#)*

The "net of social control" is the system of requirements and interventions by social institutions, usually related to criminal justice, that reduce individual liberty. In the implementation of intermediate sanctions, reference is made to both the widening of the net, that is, including ever-larger numbers and types of people, and the tightening of the net, that is, imposing ever-greater restrictions or requirements on those people.

In combining treatment with intermediate sanctions, the concern is that in the name of providing needed services (of treating people who really need it), the two systems will collaborate to use intermediate sanctions inappropriately. The concern is that such sanctions will be used for people whose offense would suggest a less intrusive response than involuntary AOD abuse treatment, or used to require more intense treatment than the offense would indicate. The concern is not primarily with the original condition requiring treatment (although that *is* a concern); the more worrisome issue is the consequences to the individual of relapse or other infractions.

Net-widening can be avoided, but it requires careful planning and monitoring. First, as the two systems plan their use of treatment in the context of intermediate sanctions, there must be broad-based agreement on the goals of the program or programs. As pointed out in [Chapter 1](#), the criminal justice system seeks many philosophical and systemic goals and values from sanctions. These must be stated clearly and explicitly, and relevant parties from both systems must acknowledge and agree to them. For example, if incapacitation is desired, then security will be an issue; if reducing jail and prison commitments is important, then only certain types of offenders should be allowed into the program.

Second, the target population -- those for whom the intermediate sanctions program is intended -- must be carefully defined. That definition will include criteria based on a combination of current offense, criminal history, personal characteristics, and treatment needs. For adequate planning, the number of individuals in the overall offender population (in jail, in prison, and on probation and parole) who meet these criteria must be determined.

Finally, it is essential to monitor intermediate sanction programs regularly to assess how closely the actual population looks like the targeted population and to evaluate how well the programs' stated goals and objectives are being met. The monitoring will also assist the jurisdiction in looking at the impact of a program on criminal justice resources, treatment resources, and target populations.

In addition to these safeguards to avoid net widening, criminal justice policymakers would be well advised to make training available to probation and parole officers, pretrial agencies, and court assessment personnel on the criteria for intermediate sanctions, on the appropriate use of AOD abuse treatment, and on the identification of voluntary treatment resources for offenders who do not meet the criteria.

Concern about net-widening must be balanced by concern for the treatment needs of those who do not fit the criteria for intermediate sanctions. The criminal justice system has an obligation to act as an advocate for increased availability of treatment resources in the community to which those offenders could be referred.

Net-tightening refers to the imposing of more restrictive or intrusive sanctions on AOD-abusing offenders because they are AOD abusing. It reflects the intense desire by some criminal justice decisionmakers and practitioners to *help* people via the sanctioning process by intervening in major ways in their lives. Their approach might be summed up by the statements, "If a little is good, a lot is better." and "We've got him, so let's cure him."

The impulse to overload an offender with conditions or requirements or to overintrude in his or her life -- relative to the seriousness of the offense or the risk of harm represented -- arises in many kinds of cases and with many types of offenders. With offenders who evidence AOD abuse, however, the impulse is particularly strong, often encouraged by treatment providers who are convinced of their own ability to offer real help to the offender.

### ***Reducing Further Opportunities for Treatment***

Offender-clients in treatment are at high risk of relapsing and reoffending. Treatment is difficult enough for high-functioning clients; offender-clients are struggling with many other issues while they try to achieve recovery. Their ability to benefit from treatment and to be successful in their first round of treatment is limited.

The need for criminal justice decisionmakers and practitioners to be educated about and aware of the stages of recovery and the likelihood of relapse has been addressed above. However, they also need to understand that without adequate support for the other, collateral issues and needs in offender-clients' lives, offender-clients are almost certain to fail. If such failure does occur, subsequent opportunities for treatment should be provided.

Unfortunately, the criminal justice system too often takes the attitude that the offender has already had his or her chance, has already been offered a valuable opportunity, and has bungled it. To some that means the opportunity should not be offered again. This outcome is particularly likely with intermediate sanctions offenders, who may be perceived by judges, prosecutors, or probation officers as having been given a double opportunity because they might otherwise have gone to prison.

---

*Unfortunately, the criminal justice system too often takes the attitude that the offender has already had his or her chances, has already been offered a valuable opportunity, and has bungled it.*

---

The criminal justice system has a responsibility to make sure that the offender-client is provided with needed ancillary services, by both the treatment provider and the supervising corrections agency, and to understand that the offender may need several attempts at treatment to achieve recovery. (It is always helpful at this point to realize how many times we or someone close to us has tried to stop smoking before finally succeeding.)

### ***Accountability***

In any collaboration between the criminal justice system and treatment providers, both the program and the offender need to be accountable. On the one hand, offender-clients represent some risk to the safety of the community if they do not cooperate with treatment and are not appropriately supervised. Treatment programs provide a much-needed service, but they generally also receive scarce public or charitable dollars to do so.

Program accountability begins with the program's providing a definition of success for its services and a reasonable expectation of how much success it will achieve; defining which services will be delivered, to whom, and how often; and setting the cost. The treatment providers and criminal justice policymakers should then negotiate around these factors, creating mutually agreed-upon outcome measures, services, and costs and putting in place the means for monitoring them. Like the agreement both systems enter into with the offender-client, this agreement should also spell out how the two systems will handle the provider's failure to meet the agreed-upon terms.

Licensing programs is one method of providing oversight of service standards. External, objective evaluators are another tool for monitoring treatment programs. However, any evaluation efforts will be limited if the programs are not required to keep aggregate data on services, completion rates, and outcomes and to provide these to the criminal justice system or to some third party.

In many jurisdictions, this kind of agreement on accountability will be difficult if not impossible: Treatment services are in short supply, and they constitute, so to speak, a seller's market. In these jurisdictions, the criminal justice system has a hard time securing any services for its clients. In still other jurisdictions, a central agency controls the allocation of treatment resources, and that agency may not have any interest in helping criminal justice agencies address concerns about accountability.

If treatment programs are made accountable for offender-client outcome, this may have the unintended effect of making treatment programs limit the types of offender-clients they are willing to take. Whether that is a problem or not, it is important to have a range of treatment services available in a jurisdiction so that there are programs specifically intended for the more difficult cases, with the accompanying lower expectations for success. It would be optimal for

treatment modalities to be available that meet a range of client needs, value systems, and cultural and psychosocial realities.

### ***Under- and Overprogramming***

Like net widening, this ethical issue is concerned with the problem of trying to match treatment needs with a sanction having a duration and intensity appropriate to the offense and the desired amount of security. Although this document has already described this matching problem as a barrier to client engagement in treatment, it is also a significant ethical dilemma.

The ethical concerns arise in a number of possible scenarios: First, a jurisdiction has a very limited array of treatment options available (or available to offender-clients). This situation occurs frequently in small, rural, or economically depressed communities; either the population or the resources are insufficient to support more varied treatment modalities. In this case, it is difficult to make the best match of client and treatment needs, and certainly very difficult to match treatment needs and appropriate sanctions. Second, the court orders a sanction based solely on the offender's assessed treatment needs, without taking into account whether the length and intensity of the sanction is appropriate to the offense. Third, the court orders a sanction that includes treatment but that is based exclusively on criminal justice goals: punishment, security, or deterrence.

Any one of these situations can result in inappropriate treatment programming, a waste of resources, and an increased likelihood of failure, both in the program and in the offender-client's meeting the conditions of the sanction. As discussed earlier, inappropriate matching can be in either direction: too little treatment or too much.

With careful planning and a willingness to invest resources, it is possible for the two systems in collaboration to take steps to avoid these problems.

First, the court must put in place a system for conducting an initial screening of offenders that identifies both a potential need for AOD treatment and eligibility for intermediate sanctions.

Second, the court should order an AOD assessment conducted by a trained professional with an accompanying treatment recommendation.

Third, the case should be assessed for the level of punishment, incapacitation, deterrence, or rehabilitation that is required, desired, or deemed appropriate; this can be done using sentencing guidelines, local intermediate sanctions policies or guidelines, a presentence investigation and recommendation by a probation officer, or by the judge's own usual practice.

Fourth, the two recommendations should be integrated, making the best match of treatment and sanction elements.

When very few treatment options are available, the two systems should work together to expand them. For example, if there is no intensive outpatient treatment available, the criminal justice system might create a day reporting center for offender supervision to which the treatment

system might assign counselors to offer treatment and consultation on the creation of other suitable activities. If the court desires more security for some offenders than a day reporting center can provide, corrections agencies may offer a home confinement option (with or without electronic monitoring) in conjunction with the day center for the time that those offenders are not at the center. The center can be used in the evening for offenders who require even less intensive treatment (as well as for self-help group meetings) or for those who have steady employment.

In addition to matching offender-clients to the right type of treatment, the sanction needs to match the length of treatment that is required. For instance, offender-clients can begin with the same treatment services, but there should be flexibility so that those who do well or who do not need extended treatment are not trapped in a court-mandated period of treatment. Some of these lengths of treatment have become almost standard: The offender is ordered into a certain number of months of treatment (or AA or NA meetings) for a particular kind or level of offense. Courts should focus on building in success or exit points for offender-clients. The case can be scheduled on the calendar for periodic review.

If programs are created with care and imagination, and screening and assessment mechanisms are put in place, it is possible to avoid over- or underprogramming.

### **Gender and Cultural Appropriateness**

Providing appropriate treatment and collateral services to particular sociocultural groups and women presents several ethical issues. While appropriate and culturally sensitive services are always desirable, they are particularly important when treatment is mandated by the court, and treatment failure can have severe repercussions for the individuals involved.

---

*While appropriate and culturally sensitive services are always desirable, they are particularly important when treatment is mandated by the court, and treatment failure can have severe repercussions for the individuals involved.*

---

### **Women's Issues**

A major issue in regard to female offender-clients is ensuring that the intermediate sanctions process does not impose restrictions or requirements on them because they are women and mothers rather than because of the offense they committed. Such requirements often take the form of restrictions related to the woman's pregnancy or requirements that relate to her parenting responsibilities -- even when these have no connection to her offense. The continuing custody of her own children (or their future custody) may be used as further coercion.

What "works" in treatment for women is often different from what works for men. Women typically have problems with self-esteem, assertiveness, and the ability to express anger. They may have experienced persistent and severe physical or sexual abuse at the hands of parents,

partners, or relatives. These issues may require programs to adjust treatment to make it more appropriate for women's empowerment and, therefore, their recovery.

The most pressing problem for women in treatment, however, is child care. Programs that offer child care -- or even more rarely, that permit children to live with their parents in inpatient treatment -- are usually full. It is almost impossible for women offender-clients to focus on and attend treatment consistently if they cannot arrange care for their children. Communities establishing collaborative programs need to assess the feasibility of providing child care services for offender-clients with children. The costs of such services probably do not approach those of putting the children in foster care, or of revoking the woman to jail or prison.

### ***Cultural Competence***

Certain modalities of treatment will not fit the values of some offender-clients whether for cultural or individual reasons. Self-help, biopsychosocial, and 12-step approaches may not be consistent with offender-clients' value systems and can therefore contribute to dropout. Treatment programs should offer different or more eclectic approaches to match offender-client values. Although matching clients and treatment modalities is in an early stage of development, it is always worthwhile to attempt to provide services consistent with the specific needs of an individual.

Effective programs should be prepared to deal with the language barriers that can impede treatment.

[Appendix C](#) provides information about cultural competence, including definitions of stages along the continuum of competence and a checklist for assessing cultural competence.

## ***Obstacles to the Effective Use of Intermediate Sanctions***

### ***Mandatory Sentences***

Many States and the Federal Government have legislated mandatory minimum terms of incarceration for drug offenses, including minor ones. In those jurisdictions, the discretion of the court has been severely limited with respect to considering intermediate sanctions in drug cases, and the only option that may be open to the judge is to sentence the individual to prison.

If the prosecutor in a given jurisdiction is willing to consider intermediate sanctions in such cases, it is possible to negotiate around this legal barrier. In some local courts, prosecutors have been willing to dismiss cases or to modify the charge (to move the case out of the mandatory category) if treatment requirements are successfully completed during an agreed-upon period. There are doubtless other ways to work around legislated prohibitions in these cases if key decisionmakers in the jurisdiction, particularly the prosecutor, are willing to do so.

### **Lack of Evaluative Research**

Little if any outcome data exist on the effectiveness of many of the intermediate sanction options described above in meeting specified objectives for particular subgroups of the offender population. The lack of outcome data is complicated by the absence in many jurisdictions of objective data about the offender population. This combination raises the possibility of sanctions being used for the wrong offender subgroup, which may jeopardize public safety and result in ineffective treatment of offender-clients. These outcomes place all efforts to implement intermediate sanctions at risk.

### **Negative Public Opinion and Misinformation About Crime**

The public's attitude toward the development of intermediate sanctions programs in a community is critical. Not only can community opposition hinder the siting of a particular treatment center or facility in an area, it can also affect the willingness of judges and prosecutors to use such intermediate sanctions as sentencing options and of legislators to fund their initial development and ongoing costs. For intermediate sanctions programs to work, there must be citizen education about the nature of crime in the community and the costs and benefits of various sentencing options and increased collaboration between the justice system, treatment personnel, and the larger community. Citizens who are well informed about intermediate sanctions programs can provide helpful input about their design and location within the community.

### **Inadequate Funding**

Most intermediate sanctions programs require new funds for start-up and operations. These costs usually are in addition to those of prison, jail, probation, and other existing options. Many State and county governments have difficulty finding the necessary funds, especially when other public services may have to be reduced or eliminated to cover these new costs. A public that has been well informed about the costs and benefits of various sentencing options can be a powerful ally at such times.

The absence of sufficient funding and resources can itself undermine this search for community support. In the absence of multiple programs, and with only the fixed resources of an existing program, local decisionmakers may overuse the program (sometimes referred to as "loving the program to death.") Stretching this resource in such a manner can dilute treatment to the point that it fails to be effective and can reduce the credibility of the treatment process.

### **Absence of Community Supports**

The difficulty in funding intermediate sanctions programs mirrors the larger problem in many communities where continued unemployment, the absence of training opportunities, and inadequate housing and health care make it more difficult for offender-clients to succeed in the community. The very large caseloads that probation officers carry make it difficult for them to serve as brokers for any available services.

## **Endnote**

<sup>1</sup>These descriptions are adapted from a list of case management functions described by the Treatment Alternatives to Street Crime (TASC) program.

Your browser does not support JavaScript

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series***

### **12**

#### **Chapter 6 -- Planning: Approaches for Developing Policy**

Planning is the most important stage in creating effective intermediate sanctions. Creating the right mechanism for doing productive planning depends on identifying and involving the appropriate policymakers in the planning process, and developing the best means for them to communicate with each other, with the public, and with others in the criminal justice and treatment communities. The planning group's work will take it through several steps: examining the current offender population, determining goals for subgroups of that population, evaluating current treatment and intermediate sanction resources, designing and implementing intermediate sanctions programs or redesigning existing programs, integrating them with other programs and services, marketing them to the community, and then continuing to monitor and evaluate progress in meeting the group's original goals.

#### **The Need for Planning**

A planning group that is representative of the criminal justice system, treatment providers, and the community is the best vehicle for carrying out these steps. Such a group encourages planners to set their sights beyond current boundaries in establishing programs and procedures that will be effective in delivering treatment services in the context of intermediate sanctions. If the two systems continue to operate the way they have been, we as a society will continue to get the results we have been getting and it is clear that in the case of AOD-involved criminal offenders, these results often are not satisfactory for the offender or the community.

The lack of proper, cross-systems planning and coordination has led to failure by offender-clients in treatment or in the criminal justice system (or both), and it is the individual offender who is seen as responsible for the failure. A more comprehensive view of the failures of these individuals, set in the context of the systems in which they occur, makes it obvious that in many cases the failure is as much that of the two systems as it is of the individual. The systems, in too

many cases, contribute to participant failure.

A planning group that spans the treatment and criminal justice systems and the community they both serve must engage in wide-ranging discussions centered around new information, and be willing to head in new directions and challenge old boundaries in a way that will have a positive impact on treatment services for the AOD-abusing offender.

Such a group can mediate the two goals that must be served simultaneously in a system that combines some form of intermediate sanctions with AOD treatment: 1) to protect public safety and 2) to help the offender achieve a drug- and crime-free life. To develop effective policies and programs, a jurisdiction must appreciate both goals and understand how achieving one serves the other. The group can also demonstrate that the two systems have other common goals and concerns, and that building a consensus is possible.

The multidisciplinary team approach is one that has worked well in many fields and will work well in this task.

A critical early step in this approach is to acknowledge that, in most places, the current approach to offenders with AOD abuse is not working.

- Incarceration is not addressing the problem of AOD abuse among offenders. A growing portion of the public and an increasing number of criminal justice and treatment representatives share this view.
- The current approach does not encourage individual success among AOD-abusing offenders. A major problem is that existing systems are designed to respond uniformly to all populations without consideration for individual needs and cultural diversities.

For ultimate success, the process of collaboration between the criminal justice and AOD treatment systems should not be limited by focusing attention only on short-range goals. The planning process must go deeper than addressing immediate needs; it must consider root problems for these AOD-abusing offenders, including unemployment, the lack of education, dysfunctional families, and the lack of adequate support systems.

A discussion of developing effective programs must begin with how they will address these issues--that is, the need to educate clients, to habilitate and rehabilitate them, to provide job training, and to match people with appropriate support systems. This will likely require programs to look beyond the criminal justice and treatment systems for continuation of care once those systems have fulfilled their goals.

## **Chapter 6 -- Planning: Approaches for Developing Policy**

Planning is the most important stage in creating effective intermediate sanctions. Creating the right mechanism for doing productive planning depends on identifying and involving the

appropriate policymakers in the planning process, and developing the best means for them to communicate with each other, with the public, and with others in the criminal justice and treatment communities. The planning group's work will take it through several steps: examining the current offender population, determining goals for subgroups of that population, evaluating current treatment and intermediate sanction resources, designing and implementing intermediate sanctions programs or redesigning existing programs, integrating them with other programs and services, marketing them to the community, and then continuing to monitor and evaluate progress in meeting the group's original goals.

## The Need for Planning

A planning group that is representative of the criminal justice system, treatment providers, and the community is the best vehicle for carrying out these steps. Such a group encourages planners to set their sights beyond current boundaries in establishing programs and procedures that will be effective in delivering treatment services in the context of intermediate sanctions. If the two systems continue to operate the way they have been, we as a society will continue to get the results we have been getting and it is clear that in the case of AOD-involved criminal offenders, these results often are not satisfactory for the offender or the community.

The lack of proper, cross-systems planning and coordination has led to failure by offender-clients in treatment or in the criminal justice system (or both), and it is the individual offender who is seen as responsible for the failure. A more comprehensive view of the failures of these individuals, set in the context of the systems in which they occur, makes it obvious that in many cases the failure is as much that of the two systems as it is of the individual. The systems, in too many cases, contribute to participant failure.

A planning group that spans the treatment and criminal justice systems and the community they both serve must engage in wide-ranging discussions centered around new information, and be willing to head in new directions and challenge old boundaries in a way that will have a positive impact on treatment services for the AOD-abusing offender.

Such a group can mediate the two goals that must be served simultaneously in a system that combines some form of intermediate sanctions with AOD treatment: 1) to protect public safety and 2) to help the offender achieve a drug- and crime-free life. To develop effective policies and programs, a jurisdiction must appreciate both goals and understand how achieving one serves the other. The group can also demonstrate that the two systems have other common goals and concerns, and that building a consensus is possible.

The multidisciplinary team approach is one that has worked well in many fields and will work well in this task.

A critical early step in this approach is to acknowledge that, in most places, the current approach to offenders with AOD abuse is not working.

- Incarceration is not addressing the problem of AOD abuse among offenders. A growing portion of the public and an increasing number of criminal justice and treatment representatives share

this view.

- The current approach does not encourage individual success among AOD-abusing offenders. A major problem is that existing systems are designed to respond uniformly to all populations without consideration for individual needs and cultural diversities.

For ultimate success, the process of collaboration between the criminal justice and AOD treatment systems should not be limited by focusing attention only on short-range goals. The planning process must go deeper than addressing immediate needs; it must consider root problems for these AOD-abusing offenders, including unemployment, the lack of education, dysfunctional families, and the lack of adequate support systems.

A discussion of developing effective programs must begin with how they will address these issues--that is, the need to educate clients, to habilitate and rehabilitate them, to provide job training, and to match people with appropriate support systems. This will likely require programs to look beyond the criminal justice and treatment systems for continuation of care once those systems have fulfilled their goals.

This does not mean that there is no consequence for relapse. The intermediate sanction plan must include consequences that can be built into the treatment protocol for each client. The treatment provider can address relapse and its consequences with increased program opportunities. Requiring an offender-client to attend an extra hour of counseling or a support group may not seem like much of a sanction, but for the client it means extra control and less freedom.

Another option for responding to relapse is a longer stay in AOD treatment, although it is important that this consideration be driven by the offender's treatment needs, not punishment. These issues are discussed at greater length in other chapters of this volume.

The continuum of treatment, sanctions, and expectations must be matched. Informed judges will understand that relapse does not mean complete failure. With effective programs in place, it will become apparent that treating the offender in the community creates a better environment for long-term change than incarceration.

## Implementation

### Defining a Target Population

The availability of adequate treatment resources is an issue for both the treatment and criminal justice systems. A court or paroling authority can order treatment, but if there is insufficient treatment capacity, the order is meaningless. Even with increases over current levels, there will still not be enough treatment resources to meet the need.

It is imperative, therefore, that the planning group make careful and explicit decisions about the best use of those resources. It must define the population for whom new and existing programs and sanctioning options are intended, and specify the outcomes that can be reasonably expected for those populations. This means making difficult choices and decisions about what would be

most beneficial for the community as well as for individual offenders.

To define appropriate populations, decide on reasonable outcomes, and make the best use of available funds, the planning team needs good information about the characteristics of the offender population in their jurisdiction that needs AOD treatment, including data on current offense, criminal and corrections history, AOD abuse history, and demographic information.

These data should be objective and quantified data, to the extent that automated systems can provide the data. If hard data are not available, anecdotal information is acceptable as a starting point until objective data can be made available. If automated systems cannot produce the necessary information, the planning group may need to use population samples and retrieve data from hard-copy files. There are often university faculty available who can advise the group on data collection methodology, and students who can do some of the collection and tabulation.

With the data, the planning team will be able to identify subgroups within the offender population, that is, groups having similar characteristics relative to AOD abuse patterns, treatment needs, offenses, and criminal history. Determinations can then be made about which groups should be targeted for treatment resources.

The planning team also needs information about the treatment resources available in the community for offender-clients. An inventory of resources may prove quite revealing, and should go beyond traditional treatment programs to take a creative look at other institutions--such as churches, charities, and universities--that may offer program possibilities. The questions that must be asked include:

- What sanctions and programs does the criminal justice system presently use with this population?
- What other resources does the criminal justice system have available to deal with this population?
- What other treatment resources are available in the community?
- How effective are various treatment modalities, particularly with this population?

Since there are not enough resources to go around, the stakeholders on the policy planning team must make choices about who is going to get what services. The team may first want to give careful consideration to the currently incarcerated offender/AOD population to determine who would benefit from intermediate sanctions programs. Broad policy must be established to address the questions and establish priorities:

- Do we give services to the people who ask for them?
- Do we give them to the offenders who are the most dangerous?
- Do we give services to offenders who have the best chance of success?
- Do we give them to offenders who are most in need?

Criteria for prioritization must include the offender's level of risk to public safety if not treated, his or her amenability to treatment, and the chances of success, in addition to whatever other factors a particular jurisdiction might choose. The planning team must decide how these various factors will be weighted in determining which offender-clients can receive treatment. They must

create programs that respond to people truly in need and be careful to avoid a potential pitfall of designing programs that respond to the easier cases and the clients who have the most supports and bypass clients with deeply entrenched problems and few supports. If the team does not decide how to weigh the various indicators of need, there is a danger of net widening by using or imposing intermediate sanction treatment programs on offenders whose crimes are not serious enough to justify such significant sanctions.

The definition of the target populations should be related as well to the other goals of intermediate sanctions. One jurisdiction may prefer to target only first offenders, while another seeks treatment for third offenders as a last opportunity to divert this group from jail.

Once its decisions have been made, the team must turn them into clear criteria for admission to the program or programs. Because of their "intermediate" nature, intermediate sanctions are appealing for a wide variety of offenders, representing a range of offenses and risk. Not all offenders are suitable for intermediate sanctions, or for those available in a particular jurisdiction. Clear criteria that have been agreed-to by the key stakeholders will serve to protect the integrity of the programs and avoid net-widening.

Once the criteria have been determined, the planning team should investigate and determine how many offenders in the jurisdiction will meet the criteria of the target population, as specified. This data-informed definition of the target population should be part of the design of the intermediate sanctions program(s).

## Allocating Resources

For effective programming, planners must carefully match the size of the target group to the available resources, and care should be taken to not overextend the resources. It is especially important as programs are being established that they not be overwhelmed. Successful programs should be replicated rather than expanded.

For maximum efficacy of programs, existing community resources should be used as adjuncts to treatment and criminal justice programs. These can include:

- Self-help groups such as Alcoholics Anonymous and Narcotics Anonymous, Rational Recovery, and Women for Sobriety
- Parenting programs
- Mentoring programs
- GED or other educational programs
- Job development, training, and placement
- Life skills management courses
- Nutrition courses
- Stress reduction programs
- Instruction for risk reduction for sexual behavior, including HIV/AIDS education
- Volunteer groups.

Using these community resources can address the collateral needs of offender-clients in a practical and affordable way that does not require additional funding. Good case management by

either or both the treatment provider and the corrections agency will provide appropriate referrals, or these resources can be integrated into the sanction itself; for example, participation in a job training program as a condition of probation. These resources should be made a part of the treatment continuum, and matched with an offender based on the assessment of his or her stage of addiction and needs in other life areas.

For new resources that will be developed, gender and cultural issues must be considered, so that the resources will match the needs and makeup of the client population. Again, funding and resources will always be limited, so appropriateness of a program for particular offenders must be considered as new options are developed.

Another way to attack the problem of limited resources is to consider reducing the size or redirecting the services of programs that may be effective but that are not addressing clients with the most need. Systems need to make a bold assessment of their needs and the priority of existing programs, and rethink how they are allocating their resources.

---

*Systems need to make a bold assessment of their needs and the priority of existing programs, and rethink how they are allocating resources.*

---

Even if the resources are available, it is important to avoid trying to put too many new programs into operation at once. New programs must be monitored for effectiveness, and while a range of options is important, going in too many directions at once will divert focus and attention.

As the planning team explores funding sources, it should also consider whatever contributions the client can make. Whenever possible, the client should pay for assessment and treatment programs, including fees for urine testing and other chemical screens. These charges can be assessed on a sliding fee scale, according to the client's ability to pay.

## **Program Management**

Once the program or programs have been developed, the planning team must choose the best way to implement them, including how they will be managed and how the collaborative process will be maintained. The decision about management will depend in part on the location of the actual programs and services. If most services are provided under the auspices of the probation agency, then a senior manager within that agency might serve as overall manager-coordinator of intermediate sanctions efforts. If the programs involve many different providers and agencies, then it may be appropriate to place responsibility with the court administrator. It is critical that the person chosen have the power and authority to maintain communication and collaboration among the key stakeholders.

The responsibility for management is not something that should be simply added to someone's existing workload. A manager must have special training, special skills, management expertise,

and the time necessary to do the job correctly. This manager should be a person who clearly understands goals of intermediate sanctions programs, who can work with everyone in the system, and who has credibility with all in the system.

### **Establishing and Maintaining Communications**

Effective, successful intermediate sanctions programs require ongoing communication, both within the treatment and criminal justice systems and between them. The policy planning team is the key to beginning this process, and that team has an obligation to put in place the mechanisms by which communication will continue. With representation from across the agencies of both systems, the planning team can identify where obstacles and opportunities exist regarding good communication.

Communication between the treatment and criminal justice systems must begin at the system level and must be carried on daily at the case level. In order to coordinate the two systems to work together for the offender, representatives from both must communicate about:

- Expectations and feasibility
- Boundaries
- Problem identification
- Means for problem solving
- Means for information sharing.

#### ***Communications of the Planning Team***

An important ingredient, which should be addressed in the planning stages, is defining how communication will take place among key players in the process in order to ensure that everyone linked to the intermediate sanctions programs is part of the communications loop, with the ability to initiate communication, receive it, and respond to it.

Planning team members can and should play an important role in facilitating communication in two directions. Team members should be a liaison between their particular discipline and the team, explaining their discipline to the team, and taking the concerns of the team back to their colleagues. As a team member, an individual becomes the listener for his or her colleagues or constituent group. He or she is also the point person, soliciting opinions to take back to the group.

#### ***Communications About Referral Criteria***

There has been considerable discussion of the problem of inappropriate referrals in this and earlier chapters. Communication is essential in avoiding such referrals.

Once the policy planning team has decided on criteria for sanctions and programs, the decisionmakers and gatekeepers in both systems should be trained not only about what the criteria are, but also about why the team chose them. In particular, the team must secure the agreement of judges to the criteria to ensure their commitment to the effort, and to avoid their

flooding the programs with offenders who need treatment but whose offense may not justify the allocation of scarce treatment resources. Probation officers, district attorneys, defense attorneys, police officers, and treatment providers should all be educated about the criteria for program participation.

### ***Communications About Clients***

To make appropriate referrals and determine whether individuals meet the criteria for program participation, decisionmakers and gatekeepers need adequate information about the offender. One of the most important sources of that information is the presentence investigation report, which is prepared by the probation department for the judge. The presentence report contains descriptive information about the offender and the offense and recommendations for sentencing. Whenever possible, the presentence report should include results of urinalysis or other chemical testing, and AOD assessment findings and recommendations.

---

*The presentence investigation report, which is prepared by the probation department for the judge, contains descriptive information about the offender and the offense and the recommendations for sentencing.*

---

Good communication rests on a foundation of sound and current information. To foster good communication, all of the players involved must be asked what information they want or require. The planning team should establish system mechanisms to obtain that information. Judges may want regular reports on program effectiveness, on the progress of individual offenders, and on offenders who do not follow the requirements of the program. Judges will require reports on offenders who violate the terms of a court order. However, it is important that feedback on offender-clients include both positive and negative information; judges and other criminal justice officials should be provided with information about offender-clients who successfully complete programs. This range of feedback can serve as a gauge of the efficacy of certain intermediate sanctions programs with particular kinds of offenders. This knowledge can guide future referrals.

Supervising corrections agencies will want to know about participants' progress in treatment, including the results of urine screens. They will begin with basic questions, such as whether offenders are reporting for treatment.

There may be issues that surface in the course of treatment that indicate a need for more or less intensive supervision. These may include ongoing criminal behavior, appointments kept and appointments missed, and individual successes in the programs. As treatment begins, treatment providers want to know the offender's criminal history, mental health or special needs history, special physical needs, and the full terms of the sentence. It is recommended that the treatment agency receive a copy of the full sentencing order. They should also have access to a presentence report. Releases and/or legislative changes may be necessary to make some of this information accessible. Because of the need for sharing information, offender-clients should be advised of the

importance of signing releases. Signing such as release may often be a condition of entering an intermediate sanctions program. It is important that this mechanism be set up from the start to facilitate smooth and continuous exchange of information between agencies.

Treatment agencies also want to know about any change in the justice status of the offender-client, and the offender-client's progress in meeting other special conditions of the sentence. These conditions may include participating in other programs, paying restitution, and meeting personal financial obligations such as paying rent and child support.

Each jurisdiction must decide for itself what sort of mechanisms will be established to facilitate the process of communication, but it is important that someone assume responsibility for ensuring that communication in individual cases is an ongoing process. The supervising agency is the logical choice for that responsibility since that agency is charged with overseeing the orders of the court in individual cases. However, it is also important to emphasize that every player has a responsibility for communication and continuing feedback.

### ***Communications Among Systems***

To facilitate continuing communications on a systems level, it is important that the intermediate sanctions planning and policy development team hold meetings on at least a quarterly basis. Attendance of members should be mandatory, or at least a top priority, for all involved.

In addition to regular meetings, other mechanisms that will facilitate communication include:

- **Letters of agreement.** These are documents between systems agreed upon at the front end of the process. They are similar to purchase of service agreements. They are designed to define boundaries between criminal justice and treatment systems and set general parameters, laying out specific criteria for admission and other conditions, so that roles and responsibilities are clearly defined. These agreements are discussed in detail in an earlier chapter.
- **Quarterly summary.** This summary is a regular report on what the program has accomplished, quantifying such items as completion rates, urine test results, and other performance indicators.
- **Program manual.** A brief baseline description of the program, including eligibility criteria, will assist communication.
- **Orientation program.** A thorough orientation must be available for all personnel involved. This is part of training, which is discussed further in the section on training.

Another level of communication involves workers communicating with each other about actual cases, as offender-clients move through both systems. This is discussed further in the section on case management in an earlier chapter.

### ***Communications With the Community***

Intermediate sanctions programs are rooted in the larger community, and continuing communication with this community as programs are being established and maintained is essential for success of the programs. As programs are in the planning stages, they must be marketed to the public. The public should be informed where the programs will be located and

what kinds of offenders will participate. They should be aware of the general theory of intermediate sanctions.

Public outreach and information can be approached in many different ways:

- **Public information, question-and-answer sessions.** It is particularly important for the planning team to reach out to victim organizations and to include them in such sessions.
- **Outreach to the media.** The media should be provided with information about a program that works, and in most cases will be only too happy to publicize success stories that will balance the usually bleak criminal justice stories that fill newspaper pages and television newscasts.
- **Speaking to community groups.** Speaking to outside groups provides something of a reality check and is a way of ensuring feedback so that planners and program designers and managers don't lose touch with what people in the community think.
- **Volunteer advisory groups.** These groups can involve interested community members without specific professional interest in the process of planning and developing programs.

However, in informing the public about these programs, it is important that information be disseminated in the context of realistic expectations for the programs--for example, some offenders in intermediate sanctions may commit crimes while in the program. But the message that these programs are largely effective can dominate.

### Promoting Treatment Goals With a Continuum of Sanctions

The concept of graduated sanctions is a primary ingredient in the effectiveness of intermediate sanctions and increases their credibility with the criminal justice system. Graduated sanctions is increasing or decreasing of requirements, levels of supervision, or limits on movement in order to ensure appropriate and consistent response by clients in all aspects of the intermediate sanctions program. There must be consequences for relapse or failure to participate in a program, but these must be consistent with the intent and sanctioning goals of the original sentence.

Some examples of graduated sanctions from the criminal justice side include:

- Increasing community service hours
- Enforcing short-term jail time
- Adding electronic monitoring to home arrest
- Adding a daily report by the offender-client to his or her probation/parole officer
- Switching from regular probation to intensive probation
- Lengthening curfew hours
- Attending a day reporting center or program
- From the treatment side, graduated sanctions might include:
  - Requiring participation in a relapse program
  - Increasing the frequency of treatment contacts
  - Increasing required attendance at AA or NA meetings
  - Increasing frequency of urinalysis
  - Moving the client to a more restrictive treatment program, for example, from outpatient to residential
  - Requiring attendance at other self-help meetings

- Adding a mentoring program
- Requiring stricter reporting of job search efforts.

It should be noted that many of these consequences are used by both systems, and that there may be treatment consequences for criminal justice violations and enhanced restrictions or requirements for treatment program failures. When the two systems support each other's goals, their actions and responses to behavior will become increasingly interrelated. It is the responsibility of the case manager to look, when necessary, for the most appropriate intervention or response and to address the situation on a continuous basis as needed. Compliance and consequences are issues that should be addressed both individually, on a case-by-case basis, and systemically by the policy team. The primary goal must be the certainty of consequences: if a client is not compliant with treatment and criminal justice requirements, neither system will allow the client to slide.

---

*The primary goal must be the certainty of consequences: if a client is not compliant with treatment and criminal justice requirements, neither system will allow the client to slide.*

---

Consequences of relapse must be written into a treatment plan, including the fact that incarceration might be an eventual consequence of repeated relapse. Incarceration, however, should only follow a series of less extreme, progressive consequences. The point of incarceration as a consequence must be specified; for example, incarceration may be required after a certain number of positive urine tests in a certain period of time. This approach is necessary to maintain credibility with the criminal justice system.

The offender's own dynamics also have to be figured into the determination of consequences. For some offenders "doing time" is preferable to "doing treatment." The case manager may need to be creative in developing meaningful responses to behavior that do not also give the offender-client a way to avoid treatment.

## Training

Training must be done across systems and must integrate personnel from both. Training can begin with a presentation from the policy planning team. Once the planning group has developed the criteria for the intermediate sanctions, group members should be prepared to make a large group presentation to the various players who will be involved. It is important that more than just a single discipline present the curriculum to the group being trained.

General topics that should be covered in training include:

- Training goals and program goals
- Common ground and common language that the AOD treatment and criminal justice systems share
- How systems and roles can be clarified

- How the two systems can effectively communicate, work together, and manage conflicts
- Cultural competence
- Confidentiality requirements
- Effective case management for the AOD-involved offender
- The rationale for intermediate sanctions programs for drug offenders
- Eligibility criteria for intermediate sanctions programs and how to apply them in individual cases
- The role of criminal justice and treatment personnel in the program
- Reporting requirements and agreements
- A broad overview of how the criminal justice and treatment systems work.

The curriculum should also cover needs and approaches to special populations in each jurisdiction, such as women, minorities, the dually diagnosed, and any other offender-clients with special needs. Input from these communities is necessary in developing the curriculum so that this material is accurate, relevant, and culturally sensitive.

Participants in training should include:

- Judges
- Prosecutors
- Probation officers
- Treatment administrators
- Treatment providers
- Clinicians
- Public treatment-funding agencies
- Defense attorneys
- Others involved with the programs.

A less detailed presentation should be provided to key policymakers, such as State and local legislators and advisors to the State or county executive. Newly appointed decisionmakers who will be involved with intermediate sanctions, such as new judges, should receive individual training.

Inservice training should be provided to practitioners in both intermediate sanctions programs and AOD treatment programs who will be handling the actual cases. This training should cover the respective needs and goals of both systems, as well as mechanics of the programs and operational requirements and expectations.

## **Monitoring and Evaluation**

One of the most important elements in implementing intermediate sanctions programs is building in the capability to learn whether sanctions are serving the populations for which they were intended, whether programs are delivering the services that they promised, and what kinds of sanctions and programs work best for which kinds of offenders. The planning team should assure that a mechanism to collect the necessary data is introduced into the design of programs from the outset. The team should also create the means for gathering and analyzing data for evaluation of program effectiveness, for monitoring, and for program redesign. In designing the program, the planning group should address these issues and either create the evaluation component itself or

create a subgroup to do so.

From the first day of planning for intermediate sanctions with AOD treatment, the development of integrated management information systems (MIS) should be part of the process. Whenever resources allow, information should be automated, so that data can be readily aggregated and analyzed. If the necessary resources (computer hardware and software and data retrieval systems that can be integrated) are not currently available, data should be collected in a form that can easily be automated. As part of the planning process, the planning group must define what it wants to measure, including particular outcomes, offender characteristics, and indicators of supervision and service delivery. Once the team has decided what it wants to know, it can seek advice on the best way and the most reliable measures to capture the information.

When resources allow, a unified database system should be set up to serve the treatment and criminal justice system needs for monitoring and evaluation. The kinds of data that such a system would capture should be chosen by the members of the planning team based on the outcomes desired and indicators selected. Data elements might include:

- New arrests
- Successful completion of treatment
- Reduced drug consumption
- Results of drug screens
- Differences in drug use
- Successful discharge from probation
- Changes in employment status
- Appointments kept and missed
- Restitution payments made or missed
- School attendance
- Personal relationships.

One specific problem that should be carefully monitored is net-widening, which would bring an offender into a more restrictive setting because it might help the offender, even though the individual's criminal offense does not justify the level of intervention. Although all of those involved in the sentencing decision contribute to the problem of net-widening, judges are probably most responsible for it. As discussed earlier in this document, the very availability of intermediate sanctions, which allow punitive and restrictive criminal justice sanctions and treatment referral without actual incarceration, can serve as an invitation to net-widening. Clear, tightly drawn criteria and a good monitoring and feedback system are the best ways to combat the problem. The team, however, has to take responsibility for developing such procedures and for using the resulting information to counter the problem by changing behavior.

As programs are implemented, the monitoring and evaluation function can help to assess a reasonable caseload. A program that is overextended will not be effective, and it is particularly vital that these first efforts be as effective as possible.

Data related to all of these issues should be communicated through a shared computerized database when possible, with common reports; a quarterly report to summarize trends, as discussed above; and periodic meetings to analyze data and determine patterns. This is important

so that the success or failure of programs can be assessed. Evaluation data must be fed back to all involved personnel so that the programs and the systems can be constantly revised and fine tuned.

To facilitate the creation of such an information system, the policy group needs to look at the resources and current capabilities of all the agencies that are involved and determine where the greatest access point is, or divide responsibilities and create a mechanism to bring information together.

The funding for the data system and for continuing monitoring and evaluation must be built into the initial funding for the program, and kept as a part of the operating budget.

## **Summary**

Through the process of planning, implementing, and monitoring an effectively combined intermediate sanctions/AOD treatment program, the planning team plays a critical role. Its responsibilities go beyond planning to oversee implementation, refine the program, and ensure its integrity in operation. To summarize, these are the tasks of the team and its members:

- Determine the goals and desired outcomes for such efforts in their jurisdiction.
- Identify the population to be served by such programs and sanctions.
- Identify the likely needs of the target population for treatment and collateral services.
- Collect data needed to confirm the intended population and their numbers in the system.
- Outline the program.
- Establish criteria for each program.
- Determine which agencies and community groups should be involved.
- Determine economic and political obstacles to intermediate sanctions.
- Participate in considerations of facility locations.
- Determine funding sources.
- Advocate for the program with funding and legislative bodies.
- Develop a political strategy to market the program to legislators. Identify legislative barriers, if any (such as mandatory minimum sentences), and recommend adoption of any needed legislative or administrative rule changes.
- Determine management information system needs.
- Oversee implementation of the program.
- Define problem areas and propose solutions.
- Ensure communication between all participants in the process.
- Advocate for what is working.
- Ensure that all subpopulations are being served effectively.
- Utilize the results of evaluations for program enhancements, translating them into direct change when the data or evaluation warrants it.

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Chapter 7 -- Ethical and Legal Issues<sup>1</sup>**

This chapter addresses legal and ethical issues that affect the structure and operation of intermediate sanctions programs run collaboratively by the alcohol and other drug (AOD) treatment and criminal justice systems. The key legal and ethical issue is protecting client confidentiality (that is, the offender-client's right to privacy).

Good communication between AOD assessment and treatment staff and criminal justice agencies is the most important component of ensuring client confidentiality. Many questions arise regarding rules and requirements of confidentiality laws:

Are there special Federal, State, and/or local rules when offenders are mandated into treatment as part of an intermediate sanction.

How can a treatment program approach various sources of information and support (for example, family, employers, and mental health providers) to assess an offender's needs without violating the offender's right to privacy.

How can the many diverse agencies concerned with or responsible for the offender's welfare communicate with each other about the offender's assessment or progress in treatment without violating confidentiality rules.

If the offender is threatening harm to him- or herself or another, can the program call the authorities.

If the offender admits he or she committed a crime, should the program call the police?

This chapter covers these issues in four sections:

- Federal laws protecting the right to privacy of any person, including an offender, when that person is seeking or receiving AOD abuse assessment or treatment services.
- Rules concerning use of consent forms to obtain an offender's permission to release information about his or her seeking or receiving AOD services, including the rule governing release of information to the criminal justice agency that mandated the offender into assessment or treatment.

- Rules for communicating with others about various issues concerning an offender who is involved with AOD abuse assessment or treatment services (including how diverse agencies can communicate with each other and whether and how an AOD program can warn others of an offender's threats to harm).
- Exceptions to the general rule that prohibits disclosure of information about persons involved with AOD abuse assessment and treatment services (for example, reporting crimes on program premises or against program personnel).

## Federal Confidentiality Laws

### Federal Laws

Two Federal laws and a set of regulations guarantee the strict confidentiality of information about persons -- including offenders -- receiving alcohol and drug abuse assessment and treatment services. The legal citation for these laws and regulations is 42 U.S.C. §§290dd-3 and ee-3 and 42 C.F.R. Part 2.

These laws and regulations are designed to protect patients' privacy rights in order to attract people into treatment. The regulations restrict communications more tightly in many instances than, for example, either the doctor-patient or the attorney-client privilege. Violation of the regulations is punishable by a fine of up to \$500 for a first offense or up to \$5,000 for each subsequent offense ([§2.4](#)).<sup>2</sup>

Federal confidentiality regulations require programs to notify patients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to offenders when they begin participating in the program or soon thereafter ([§2.22\(a\)](#)). The regulations also contain a sample notice.

Programs can use their own judgment to decide when to permit offenders to view or obtain copies of their records, unless State law grants clients the right of access to records. Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records.

Federal regulations require programs to keep written records in a secure room, a locked file cabinet, or other similar safe location or container. The program should establish written procedures that regulate access to and use of offenders' records. Either the program director or a single staff person should be designated to process inquiries and requests for information ([§2.16](#)).

Some may view these Federal regulations as an irritation or a barrier to achieving program goals. However, most problems that may crop up under the regulations can be avoided through planning. Familiarity with regulation requirements will ease communication. It can also reduce confidentiality-related conflicts with programs, patients, and criminal justice agencies.

## **State and Local Laws and Regulations**

A myriad of State and local laws on confidentiality also exist. These laws may conflict with or complement Federal confidentiality regulations. AOD treatment programs should determine their requirements by consulting with legal counsel familiar with State, local, and Federal laws and regulations that affect their programs.

A local practitioner is the best source for advice on such issues. Moreover, when it comes to certain issues, the law is still developing. For example, programs' "duty to warn" about client threats to harm others is constantly changing as courts in different States consider cases brought against different kinds of care providers. Programs trying to decide how to handle such situations need up-to-the-minute advice on their legal responsibilities.

## **Programs Governed by the Regulations**

Any program that specializes, in whole or in part, in providing treatment, counseling, or assessment and referral services for offenders with AOD problems must comply with the Federal confidentiality regulations (42 C.F.R. §2.12(e)). The Federal regulations apply to programs that receive Federal assistance, including indirect forms of Federal aid (for example, tax-exempt status or State or local government funding received, in whole or in part, from the Federal Government).

Coverage under the Federal regulations is based on the kind of services provided. A program cannot avoid coverage by labeling its services differently (for example, by using such terms as "prevention program" or "assessment program").

## **The General Rule**

Federal confidentiality laws and regulations protect any information about an offender if the offender has applied for or received any AOD-related services from a program that is covered under the law. Services applied for or received can include assessment, diagnosis, individual counseling, group counseling, treatment, or referral for treatment. The restrictions on disclosure apply to any information that would identify the offender as an alcohol or other drug abuser, either directly or by implication.<sup>3</sup> The general rule applies from the time the offender makes an appointment.<sup>4</sup> It applies to offenders who are mandated into treatment as well those who enter treatment voluntarily. It also applies to former clients or patients. The rule applies whether or not the person making an inquiry already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.

## **Sharing Confidential Information**

Information that is protected by Federal confidentiality regulations may always be disclosed after the offender has signed a proper consent form.<sup>5</sup> The regulations also permit disclosure without the offender's consent in several situations, including medical emergencies, program evaluations, and communications among program staff.

Typically, AOD programs will seek to obtain the offender's consent in order to make a disclosure that would otherwise be prohibited. The regulations provide for two different kinds of consent forms for clients mandated into assessment or treatment by the criminal justice system (§§2.31 and 2.35):

- Special criminal justice system consent form for communications between an AOD program and the person or entity within the criminal justice system that mandated the offender's compliance with assessment or treatment ([Exhibit 7-1](#)).
- General consent form, authorized by Federal regulations, for all other consented disclosures ([Exhibit 7-2](#)).

Federal regulations regarding consent are unusual and strict and must be carefully followed.

### ***Refusal to Sign a Consent Form***

Offenders who refuse to sign consent forms permitting essential communications can be excluded from treatment or provided treatment temporarily in the hope that resistance to signing the consent forms will evaporate as treatment proceeds.

### ***Disclosure of AOD Information***

Most disclosures are permissible if an offender has signed a valid consent form that has not expired or has not been revoked (§2.31).<sup>6</sup> A proper consent form must be in writing and must contain each of the items contained in §2.31, including:

- The name or general description of the program(s) making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the client who is the subject of the disclosure
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
- The date, event, or condition upon which the consent expires if not previously revoked
- The signature of the client
- The date on which the consent is signed (§2.31(a)).

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. A number of items that deserve further explanation, including the purpose of the disclosure and how much and what kind of information will be disclosed, the offender's right to revoke the consent statement, expiration of the consent form, required notice against rereleasing information, and the discretion of the agency to release information authorized by the consent form.

## **Purpose of Disclosure and Disclosable Information**

The purpose of the disclosure and the information to be disclosed are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§2.13(a)). It would be improper to disclose everything in an offender's file if the recipient of the information needs only a specific piece of information.

In completing a consent form, it is important to determine the purpose or need for the communication of information. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the identified need or purpose.

As an illustration, if the fact that an offender is in treatment needs to be documented so that the offender can be eligible for a benefit program such as home relief, the purpose of the disclosure would be "to obtain home relief benefits" and the amount and kind of information to be disclosed would be "enrollment in treatment." The disclosure would then be limited to a statement that "Emily Johnson [the offender-client] is participating in treatment at the XYZ Program." No other information about the offender would be released.

## **Offender's Right to Revoke Consent**

The general consent form authorized by Federal regulations permits offenders to revoke consent at any time (orally or in writing), and the consent form must include a statement to this effect. This is a key difference between the general consent form and the criminal justice system referral consent form -- the latter of which does not permit revocation (see below).

If a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent (that is, the program was relying on the consent form when it made the disclosure). Therefore, the program is not required to try to retrieve the information it has already disclosed.

The regulations state that "acting in reliance" includes the provision of services while relying on the consent form to permit disclosures to a third-party payer. (Third-party payers are health insurance companies, Medicaid, or any party that pays the costs of services other than the client's family or the treatment agency.) Thus, a program can bill the third-party payer for past services provided before consent was revoked. However, a program that continues to provide services after a client has revoked a consent form authorizing disclosure to a third-party payer does so at its own financial risk.

## **Expiration of Consent Form**

The form must also contain a date, event, or condition on which it will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a) (9)).

It is better practice to think through how much time the consent form should include rather than have all consent forms within a treatment agency expire within a standard time frame (for example, within 60 or 90 days). When uniform expiration dates are used, agencies can find themselves in a situation where there is a need for the disclosure, but the client's consent form has expired. This means at the least that the client must come to the agency again to sign a consent form. At worst, the client has left the program or is unavailable (for example, in the hospital or incarcerated), and the agency will not be able to make the disclosure.

The consent form does not need to contain a specific expiration date but may instead specify an event or condition. For example, if an offender has been placed on probation at school or work on the condition that he or she attend counseling at the program, a consent form should be used that expires after completion of the probationary period. Or if an offender is being referred to a specialist for a single appointment, the consent form should provide that it will expire after he or she has seen "Dr. X."

### **Required Notice Against Re-Release**

Any disclosure made with written client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the person receiving the information cannot make any further disclosure of such information unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be explained and provided to the recipient of the information at the time of disclosure or earlier (see [Exhibit 7-3](#)).

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from re-releasing information except as permitted by the regulations. (However, an offender may sign a consent form authorizing such a redisclosure.)

### **Discretion of Agency to Determine Release**

The fact that an offender has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b); 2.61(a)(b)). The program's only obligation is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or invalid (§2.31(c)).

In most cases, the decision whether to make a disclosure pursuant to a consent form is within the discretion of the program unless State law requires or prohibits disclosure once consent is given. In general, it is best to use the following rule: disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose of the communication.

### **Special Rules on Consent Forms**

As described above, programs assessing and treating offenders must follow the confidentiality rules that generally apply to AOD programs. However, some special rules apply to disclosure of information to the mandating criminal justice agency (that is, the agency requiring an offender to

come for AOD assessment or treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of any criminal proceeding).

### ***Length of Time Consent Is Valid***

A consent form (or court order) is still required before any disclosure can be made about an offender who is mandated into AOD assessment or treatment. Federal regulations require that the following factors be considered in determining how long a consent form will remain in effect:

- The anticipated duration of treatment
- The type of criminal proceeding in which the offender is involved
- The need for treatment information in dealing with the proceeding
- When the final disposition will occur
- Anything else the patient, program, or criminal justice agency believes is relevant.

Rules governing a criminal justice system consent form differ from the general consent form. The criminal justice consent form cannot be revoked before its expiration event or date. In addition, the rules concerning the length of time that a consent remains valid are different.

The above Federal rules allow programs to continue to use a traditional expiration condition for a consent form (that is, "when there is a substantial change in the patient's justice system status"). This was formerly the only standard in existence. This formulation appears to work well. A substantial change in status occurs whenever the offender moves from one phase of the criminal justice system to the next.

For example, if an offender is on probation or parole and is in an AOD program as a condition of probation or parole, there would be a change in criminal justice status when the term of probation or parole ends, either by successful completion or revocation. Thus, the program could provide an assessment or periodic treatment reports to the probation or parole officer monitoring the offender, and could even testify at a probation or parole revocation hearing if it so desired, since no change in criminal justice status would occur until after that hearing.

### ***Revocability of Consent***

As for the revocability of consent (the rules under which the offender can take back his or her consent), Federal regulations provide that the consent form can state that consent cannot be revoked until a certain specified date or condition occurs. The regulations allow the criminal justice system consent form to be irrevocable so that an offender who has been required to enter treatment in lieu of prosecution or as part of an intermediate sanction cannot then prevent the court, probation department, or other agency from monitoring his or her progress. Note that although a criminal justice system consent may be made irrevocable for a specified period of time, its irrevocability must end no later than the final disposition of the criminal proceeding.<sup>7</sup> Thereafter, the offender may freely revoke consent.

### ***Other Rules***

Several other considerations relating to criminal justice system referrals are important.

First, any information one of the eligible criminal justice agencies receives from a treatment program can be used by that justice agency only in connection with its official duties with respect to that particular criminal proceeding. The information may not be used in other proceedings, for other purposes, or with respect to other individuals (§2.34(d)).

In addition, whenever possible, it is best to have the judge or referring agency require that a proper criminal justice system consent form be signed by the offender before he or she is referred to the treatment program. If that is not possible, the treatment program should have the offender sign a criminal justice system consent form at his or her very first appointment. With a proper criminal justice consent form signed, the AOD program can communicate with the referring criminal justice agency even if the offender appears for assessment or treatment only once. This avoids the unfortunate problems that can arise if an offender mandated into assessment or treatment does not sign a proper consent form and leaves before the assessment or treatment has been completed.

If a program fails to have the offender sign a consent form and the offender fails to complete the assessment process or treatment, the program has few options when faced with a request for information from the referring criminal justice agency. The program could attempt to locate the offender and ask him or her to sign a consent form, but that, of course, is unlikely to happen. And there is some question whether a court can issue an order to authorize the program to release information about a referred offender who has left the program in this type of case. This is because the regulations allow a court to order disclosure of treatment information for the purpose of investigating or prosecuting a patient for a crime only when the crime was "extremely serious." A parole or probation violation generally will not meet that criterion.

Therefore, unless a consent form is obtained by the judge or criminal justice agency or by the treatment program at the very beginning of the assessment or treatment process, the program may end up in a position where it is prevented from providing any information to the criminal justice agency that referred the offender.

If the offender referred by a criminal justice agency never applies for or receives services from the program, that fact may be communicated to the referring agency without patient consent (§2.13(c)(2)). But once an offender even makes an appointment to visit the program, consent or a court order is needed for any disclosures.

A final note: When a program decides to establish an ongoing relationship with a criminal justice system agency, it is best to have a complete discussion about the objectives of each partner, the expectations each partner has about the obligation of the other, and about communications between the program and the criminal justice agency. For programs treating offenders, issues such as who will make certain decisions and what kinds of information will be reported are crucial. For example, it is important to specify whether the treatment program or the criminal justice agency will decide when an offender's relapse into AOD use is a treatment issue or a

violation of the conditions of probation. It is also important to decide how detailed the program's reports to the criminal justice agency will be. Matters such as these should be resolved between the program and criminal justice agency before problems arise in individual cases. A memorandum of understanding or letter of agreement should be drafted to set forth agreed-upon rules.

## Communicating With Others

Given these rules regarding consent, consider the questions introduced at the beginning of this chapter: How can programs seek information from collateral sources about offenders they are assessing. How can the many diverse criminal justice and treatment agencies effectively communicate without violating Federal rules. Do programs have a duty to warn others of threats by offenders, and if so, how do they communicate the warning. Should programs inform the police when the offender admits he or she committed a crime?

### Seeking Information From Collateral Sources

Making inquiries of employers, schools, doctors, and other health care entities might, at first glance, seem to pose no risk to an offender's right to confidentiality. But it does.

When a program that screens, assesses, or treats offenders asks another individual or entity to verify information it has obtained from the offender, it is making a patient-identifying disclosure that the offender has sought its services. Federal regulations generally prohibit this kind of disclosure unless the offender consents.

How then is a screening or assessment program to proceed. The easiest way is to get the offender's consent to contact the employer, family member, school, AOD program, health care facility, and so forth. The general AOD consent form (not the criminal justice system consent form) is the appropriate form.

As noted above, when filling out the consent form, thought should be given to what the purpose of the disclosure is and how much and what kind of information will be disclosed. For example, if a program is assessing an offender for treatment and seeks records from a mental health provider, the purpose of the disclosure would be "to obtain mental health treatment records to complete the assessment." The kind of information disclosed would then be limited to a statement that "Paul O'Neal [the offender] is being assessed by the XYZ Program." No other information about Paul O'Neal would be released to the mental health provider.

If the program seeks not only records, but needs to discuss with the mental health provider the treatment it provided the offender, the purpose of the disclosure would be "to discuss mental health treatment provided to Paul O'Neal by the mental health program." If the program merely seeks information, the kind of information disclosed would, as in the example above, be limited to a statement that "Paul O'Neal is being assessed by the XYZ Program." However, if the program needs to disclose information it gained in its assessment of Paul O'Neal to the mental health provider to further the discussion, the kind of information disclosed would be "assessment information about Paul O'Neal."

A program that routinely seeks collateral information from many sources could consider asking the offender to sign a consent form that permits it to make a disclosure for purposes of seeking information from collateral sources to any one of a number of entities or persons listed on the consent form. Note that this combination form must still include the name or title of the individual or the name of the organization for each collateral source the program may contact. Whichever method the program chooses, it must use the general consent form, not the special criminal justice system consent form.

Programs should keep in mind that even when information is disclosed over the telephone, they are still required to notify the recipients of the prohibition on redisclosure. Mention should be made of this restriction during the conversation; for example, program staff could say, "I'll be sending you a written statement that the information I gave you about Mr. O'Neal cannot be redisclosed."

### **Communicating With the Referring Criminal Justice Agency**

Generally, the criminal justice consent form should be used for gaining client consent for communications with the criminal justice agency that referred the offender to assessment or treatment. Use of this form is important to ensure that offenders cannot revoke consent prior to the expiration date (that is, upon entry into the AOD treatment program). Circumstances for assessment and treatment programs are described below.

Programs performing assessments of offenders mandated to AOD services need to be able to communicate with the referring criminal justice agency for a brief span of time (that is, long enough to perform the assessment, write a report, and make a presentation to the court or agency). Programs performing assessments should have the offender sign a criminal justice system consent form that expires after the offender's next change in criminal justice status.

For example, suppose the offender has been convicted of a crime and has not yet been sentenced but is being considered for intensive supervision probation. The program performing the assessment (Program A) should make sure that the offender signs a criminal justice system consent form that expires after the offender's sentencing. In that way, Program A is assured of being able to continue communicating with the agency that referred the offender (whether it is the court or probation department) until a final decision has been reached.

Programs providing treatment need to be able to communicate with the referring criminal justice agency over an extended period of time. Therefore, Program B, the agency to which the offender is assigned for his or her mandated treatment, should have the offender sign a criminal justice system consent form permitting communication with the referring criminal justice agency until the period of community supervision -- probation or parole -- is completed, either successfully or through revocation proceedings.

### **Communications Between AOD Programs**

A consent form is also required for release of information between AOD programs. The following examples illustrate this requirement.

**Example 1.** The agency in which the offender has been placed for treatment after sentencing (Program B) wants to see the treatment assessment completed by Program A. Program B will need a client consent form to get a copy from Program A and a different consent form to get a copy from the mandating criminal justice agency.

The assessment report prepared by Program A may well be a part of the offender's criminal justice record maintained by the probation department. But it is still protected by Federal regulations and cannot be released to Program B, or anyone else, without the offender's consent.

If Program B needs the assessment report prepared by Program A, it should have the offender sign two consent forms -- one permitting it to ask Program A for the report (since Program A has now become a collateral source) and another permitting Program A to release the report to Program B.<sup>8</sup>

**Example 2.** As noted above, Program B must also have the offender sign a criminal justice system consent form permitting it to have ongoing communications with the criminal justice agency that mandated the offender into treatment. All other communications by Program B with the outside world, including other criminal justice agencies, must be dealt with on an individual basis: either by consent or by ensuring that the proposed disclosure falls within one of the other narrow exceptions.

### **Communications for Clients Who Change AOD Programs**

Consent and confidentiality issues should also be considered in situations when an offender's treatment provider changes. For example, an offender may be treated for AOD abuse in a jail or prison and then referred to aftercare at a community-based program. The treatment record compiled by the correctional facility can be released to the community-based program, but only with the offender's consent. Similarly, when an offender has been treated in a community-based treatment program as part of a term of probation or parole and probation or parole is then revoked, resulting in incarceration, an AOD assessment or treatment program in a correctional facility can obtain the AOD treatment records that were compiled by the community-based AOD treatment program only with the offender's consent.

Jurisdictions that are considering establishing a system of comprehensive treatment for offenders along the entire criminal justice continuum, and that would like to encourage a flow of information about those offenders in treatment, should air and settle confidentiality questions before the system is up and running. Planners may find that using consent forms is the most sensible way to deal with questions about how protected information can flow from arrest through incarceration through parole and back. As the offender enters each phase of the system, he or she can sign a series of consent forms that will enable the AOD program to 1) gain information from AOD programs in the system that previously treated the offender and 2) communicate with the necessary criminal justice entities. As the offender leaves each phase of the system, he or she can sign a series of consent forms that will enable the AOD program to disclose information to programs that will treat the offender in the next phase (for example, during parole).

## Ongoing Communications Among Agencies

AOD programs treating offenders often provide case management for their clients. Therefore, they frequently need to be able to communicate on an ongoing basis with a referral source or other service providers, such as mental health agencies or child welfare officials.

Again, client consent is required before such communication can occur. Care should be taken in wording the consent form to permit the kinds of communications necessary.

For example, if the program needs ongoing communications with a mental health provider, the purpose of the disclosure would be "coordination of care (or case management) for Kate Sampson" and how much and what kind of information will be disclosed might be "treatment status, treatment issues, and progress in treatment."

If the program is treating a client who is on probation at work and whose continued employment is contingent on treatment, the purpose of the disclosure might be "to assist the client to comply with employer's mandates" (or "supply periodic reports about treatment") and how much and what kind of information will be disclosed might be "progress in treatment."

Note that the kinds of information that will be disclosed in the two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider if that would assist in coordinating care. Disclosure to an employer would most likely be limited to a brief statement about the client's progress in treatment. Disclosure of clinical information to an employer would, in most circumstances, be inappropriate.<sup>9</sup>

The program should also determine the consent form's expiration date or the event for expiration. For coordinating care with a mental health provider, it might be appropriate to have the consent form expire when treatment by either party ends. A consent form permitting disclosures to an employer might expire when the client's probationary period at work ends.

## Duty to Warn

For most treatment professionals, the issue of reporting a patient's threat to harm another or to commit a crime is a troubling one. Many professionals feel that they have an ethical, professional, or moral obligation to prevent a crime when they are in a position to do so, particularly when the crime is a serious one.

There has been a developing trend in the law to require psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for money damages because he failed to warn a potential victim his patient threatened to kill and then killed. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

While the *Tarasoff* ruling, strictly speaking, applies only in California, courts in a number of other States have followed *Tarasoff* in finding therapists liable for money damages when they failed to warn someone threatened by a patient. Most of these cases are limited to situations in which patients threaten a specific identifiable victim. They do not usually apply when a patient makes a general threat without identifying the intended target. States that have enacted laws on the subject have similarly limited the duty to warn to such situations.

In a situation where a program thinks it might be faced with a "duty to warn" question, there are always at least two -- and sometimes three -- questions that need to be answered:

- Is there a legal duty to warn in this particular situation under State law?
- Even if there is no State legal requirement to warn the intended victim or the police, does the program feel a moral obligation to warn someone?

The first question can only be answered by an attorney familiar with the law in the State in which the program operates. If the answer to the first question is "no," it is also advisable to discuss the second question with a knowledgeable lawyer.

- If the answer to the first or second question is "yes," can the program warn the victim or someone likely to be able to take action without violating Federal AOD regulations?

The problem is that there is an apparent conflict between Federal confidentiality requirements and the "duty to warn" imposed by States that have adopted the principles of *Tarasoff*. Simply put, Federal confidentiality law and regulations prohibit the type of disclosure that *Tarasoff* and similar cases require,<sup>10</sup> unless the AOD program can make a disclosure by using one of the regulations' narrow exceptions.

There are five ways a program can proceed when an offender makes a threat to harm himself or herself or another and the program decides to report the threat:

- The program can make a report to the criminal justice agency that mandated the offender into treatment, so long as it has a criminal justice system consent form signed by the offender that is worded broadly enough to allow this sort of information to be disclosed. The criminal justice agency can then act on the information. However, the regulations limit what the criminal justice agency can do with the information. Section 2.35(d) states that anyone receiving information pursuant to a criminal justice system consent "may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given."
- Thus, the disclosure can be used by the referring criminal justice agency to revoke an offender's conditional release or probation or parole. If the referring criminal justice agency wants to warn the victim or to notify another law enforcement agency of the threat, it must be careful that no mention is made that the source of the tip was an AOD program or that the offender is in AOD assessment or treatment. (Disclosures that do not identify the offender as someone with an AOD problem are permitted. See the discussion of this exception below.) However, the disclosure most likely cannot be used to prosecute the offender for a separate crime (in other words, for making the threat). The only way to prosecute an offender based on information obtained from a program is to obtain a special court order in accordance with §2.65 (see below).

- The program can go to court and request a court order authorizing the disclosure. The program must take care that the court abides by the requirements of Federal AOD regulations. (See the discussion of the court order exception below.)
- The program can make a disclosure that does not identify the individual who threatens to commit the crime as an AOD client. This can be accomplished either by making an anonymous report or -- for a program that is part of a larger non-AOD entity -- by making the report in the larger entity's name. For example, a counselor employed by an AOD program that is part of a mental health facility could phone the police or the potential target of an attack, identify herself as "a counselor at the New City Mental Health Clinic," and explain the risk to the potential target. This would convey the vital information without identifying the client as an AOD abuser. Counselors at freestanding AOD units cannot give the name of the program.
- The program can make a report to medical personnel if the threat presents a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical intervention (§2.51). (See the discussion of the medical emergency exception below.)
- The program can obtain the client's consent, although it is unlikely to be granted.<sup>[11](#)</sup>

If none of these options is practical, and a program believes there is a clear and imminent danger to a client or a particular person, it is probably wiser to err on the side of making an effective report about the danger to the authorities or to the threatened individual. This is especially true in States that already follow the *Tarasoff* rule.

While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a counselor who warned about potential violence when he or she believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn may well result if the threat is actually carried out. In any event, the counselor should try to make the warning in a manner that does not identify the individual as an AOD abuser.

Duty to warn issues present an area in which staff training, as well as a staff review process, may be helpful.

## Reporting Criminal Activity Of Clients

### Intention to Commit Criminal Activity

What should a program do when a client tells a counselor that she intends to get her children new clothes by shoplifting (a crime the counselor knows she has committed many times in the past). Does the program have a duty to tell the police?

A program generally does not have a duty to warn another person or the police about a client's intended actions unless the client presents a serious danger of violence to an identifiable individual. Shoplifting rarely involves violence, and it is unlikely that the counselor will know which stores are to be victimized. Petty crime like shoplifting is an important issue that should be dealt with therapeutically. It is not something a program should necessarily report to the police.

## **Disclosure of a Previously Committed Crime**

Does a program have a responsibility to call the police when a client discloses to a counselor that he participated in a serious crime some time in the past?

Suppose that a client admits during a counseling session that he killed someone during a robbery 3 months ago. Here the program is not warning anyone of a threat, but serious harm did come to another person. Does the program have a responsibility to report that?

In a situation where a program thinks it might have to report a past crime, there are generally three questions that need to be answered:

Is there a legal duty to report the past criminal activity to the police under State law. Generally, the answer to this question is no. In most States, there is no duty to report a crime committed in the past to the police. Even in those States in which failure to report a crime is considered a crime, violations of the law are rarely prosecuted.

Does State law permit a counselor to report the crime to law enforcement authorities if he or she wants to. Whether or not there is a legal obligation imposed on citizens to report past crimes to the police, State law may protect conversations between counselors of AOD programs and their clients and exempt counselors from any requirement to report past criminal activity by clients. Such laws are designed to protect the special relationship AOD counselors have with their clients.

State laws vary widely on the protection they accord communications between clients and counselors. In some States, admissions of past crimes may be considered privileged and counselors may be prohibited from reporting them; in others, admissions may not be privileged. Moreover, each State defines the kinds of relationships protected differently. Whether a communication about past criminal activity is privileged (and therefore cannot be reported) may depend upon the type of professional the counselor is and whether he or she is licensed or certified by the State.

Any program that is especially concerned about this issue should ask a local attorney for an opinion letter about whether there is a duty to report and whether any counselor-patient privilege exempts counselors from that duty.

If State law requires a report (or permits one and the program decides to make a report), how can it comply with both Federal confidentiality regulations and State law. Any program that decides to make a report to law enforcement authorities about a client's prior criminal activity must do so without violating either Federal confidentiality regulations or State laws. A program that decides to report a client's crime can comply with Federal regulations by following one of the first three methods described above in the discussion of duty to warn.

- It can make a report to the criminal justice agency that mandated the offender into treatment, if it has a criminal justice system consent form signed by the offender that is worded broadly enough to allow this sort of information to be disclosed.

- It can obtain a court order permitting it to make a report if the crime is sufficiently serious.
- It can make a report in a way that does not identify the individual as an AOD client.

Because of the complicated nature of this issue, any program considering reporting a client's admission of criminal activity should seek the advice of a lawyer familiar with local law as well as Federal regulations.

## **Other Exceptions to the General Rule**

Reference has been made to other exceptions to Federal confidentiality rules prohibiting disclosure regarding offenders who are assessed or treated for AOD abuse. Eight additional exceptions to the general rule on confidentiality exist:

- Information that does not reveal the client is an AOD user
- Information shared with staff within the treatment program; information shared inside the agency with staff not part of the assessment or treatment unit
- Information regarding crimes on program premises or against program personnel
- Reporting child abuse or neglect
- Information disclosed to an outside agency that provides the program with services
- Information disclosed in a medical emergency
- Disclosures authorized by a special court order
- Information disclosed to researchers, auditors, and evaluators

## **Communications Not Disclosing Patient-Identifying Information**

Federal regulations permit programs to disclose information about an offender if the program reveals no patient-identifying information. Patient-identifying information is information that identifies someone as an AOD abuser. Thus, a program may disclose information about an offender if that information does not identify him or her as an AOD abuser or support anyone else's identification of the offender as an AOD abuser.

There are two basic ways a program may make a disclosure that does not identify a client.

**Aggregate information.** A program can report aggregate data about its population (summing up information that gives an overview of the clients served in the program) or some portion of its population. Thus, for example, a program could tell the newspaper that in the last 6 months it screened 43 offenders, 10 female and 33 male.

**Release of information that does not indicate or imply the AOD status of the client.** A program can communicate information about an offender in a way that does not reveal the offender's status as an AOD treatment patient (§2.12(a)(i)). For example, a program that provides services to clients with other problems or illnesses as well as AOD abuse may disclose information about a particular client as long as the fact that the client has an AOD abuse problem is not revealed. An even more specific example: A program that is part of a general hospital could have a counselor call the police about a threat a client made, as long as the counselor does

not disclose that the client has an AOD abuse problem or is a client of the AOD abuse treatment program.

Programs that provide only AOD services or that provide a full range of services but are identified by the general public as AOD programs cannot disclose information that identifies a client under this exception, since letting someone know a counselor is calling from the "XYZ Treatment Program" will automatically identify the offender as someone in the program. However, a freestanding program can sometimes make anonymous disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the offender's status as an AOD abuser.

### **Communications Among Treatment Staff**

Federal regulations permit some information to be disclosed to individual staff within the same program. Restrictions on disclosure do not apply to communications of information among personnel 1) within a program or 2) between a program and an entity that has direct administrative control over that program (§2.12(c)(3)). Such communications can occur only if the personnel have a need for the information in connection with their duties in providing diagnosis, treatment, or referral for treatment of AOD abuse.

In other words, staff who have access to patient records because they work for or administratively direct the program (including full-time or part-time employees and unpaid volunteers) may consult among themselves or otherwise share information if their AOD treatment work so requires (§2.12(c)(3)). And staff may communicate patient-identifying information to a person or entity having "direct administrative control" over a program if there is a need for the information "in connection with their [AOD] duties."

### **Communications Among Nonclinical Staff**

A question that frequently arises is whether this exception allows a program that assesses or treats offenders and that is part of a larger entity (such as a probation department) to share confidential information with others who are not part of the assessment or treatment unit itself. The answer to this question is among the most complicated in this area. In brief, there are circumstances in which the assessment unit can share information with other units, but it is essential before such a system is set up that an expert in the area be consulted for assistance.

Two crucial issues must be considered.

- The program must always keep in mind that it may communicate only information that will assist it or the supervisory entity to provide AOD services.
- Once communications are made to an entity having administrative control over the program, that entity becomes part of "the program," and it is now subject to Federal confidentiality regulations. This means that personnel in that entity must become familiar with the Federal rules and that information they gain from the AOD program cannot be redislosed to anyone else, unless the offender consents or one of the other exceptions in the Federal regulations applies.

## **Crimes on Program Premises or Against Program Personnel**

When an offender has committed or threatened to commit a crime on program premises or against program personnel, the regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, without any special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a patient at the program (§2.12(c)(5)).

## **Reporting Child Abuse and Neglect**

All 50 States and the District of Columbia have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral (usually telephone) report and many now have toll-free numbers to facilitate reporting. (Half the States require both oral and written reports.) All States extend immunity from prosecution to persons reporting child abuse and neglect. (In other words, a person who reports child abuse or neglect cannot be brought into court.) Most States provide for penalties for failure to report.

Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. Thus, if an offender reveals to program staff that he or she has neglected or abused children, that fact may well have to be reported to State authorities. Note, however, that this exception to the general rule prohibiting disclosure of any information about a client applies only to initial reports of child abuse or neglect. Programs may not respond to followup requests for information or to subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, unless the offender consents or the appropriate court issues an order under subpart E of the regulations.

Because of the variation in State laws, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance.

## **Qualified Service Organization Agreements**

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into what is known as a qualified service organization agreement (QSOA). A QSOA is a written agreement between a program and a person or entity providing services to the program, in which that person or entity: 1) acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the program, he, she, or it is fully bound by [Federal confidentiality] regulations; and 2) promises that, if necessary, he, she, or it will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations (§2.11, 2.12(c)(4)). A sample QSOA is provided in [Exhibit 7-4](#).

A QSOA should be used only when an agency or official outside of the program is providing a service to the program itself. An example is when laboratory analyses or data processing is performed for the program by an outside agency.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that the program can function effectively. QSOAs may not be used between programs providing AOD services.

### **Medical Emergencies**

A program may make disclosures to public or private medical personnel "who have a need for information about [an offender] for the purpose of treating a condition which poses an immediate threat to the health" of the offender or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The exception permits disclosure only to medical personnel. This means that it cannot be used as the basis for a disclosure to the police or other nonmedical personnel, including family.

Whenever a disclosure is made to cope with a medical emergency, the program must document in the offender's records:

- The name and affiliation of the recipient of the information
- The name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency.

### **Court-Ordered Disclosures**

A State or Federal court may issue an order that will permit a program to make a disclosure about an offender that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information<sup>12</sup> (§2.61).

Before a court can issue a court order authorizing a disclosure about an offender, the program and any offenders whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court.<sup>13</sup> Generally, the application and any court order must use fictitious (made-up) names for any known offender, and all court proceedings in connection with the application must remain confidential unless the offender requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find good cause only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the patient, the

doctor-patient or counselor-patient relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)). The judge may examine the records before making a decision (§2.64(c)).

If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a patient for a crime, the court must also find that:

- The crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury
- The records sought are likely to contain information of significance to the investigation or prosecution
- There is no other practical way to obtain the information
- The public interest in disclosure outweighs any actual or potential harm to the patient, the doctor-patient relationship, and the ability of the program to provide services to other patients.

When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel. (If the program is a governmental entity, it must be represented by counsel.) (§2.65(d).)

There are also limits on the scope of the disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the offender's confidentiality, including sealing court records from public scrutiny (§§2.64(e), 2.65(e)).

The court may order disclosure of "confidential communications" by an offender to the program only if the disclosure:

- Is necessary to protect against a threat to life or of serious bodily injury
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse)
- Is in connection with a proceeding at which the offender has already presented evidence concerning confidential communications (for example, "I told my counselor...") (§2.63).

### **Research, Audit, or Evaluation**

Research and evaluation of the efficacy of AOD treatment for offenders are essential if criminal justice agencies are to increase their interest in and use of AOD treatment as part of intermediate sanctions. But can AOD programs share patient-identifying information with researchers and program evaluators?

The confidentiality regulations permit programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, providing certain safeguards are met (§§2.52, 2.53).

## ***Research***

AOD programs can disclose patient-identifying information with persons conducting "scientific research" if the program director determines that the researcher 1) is qualified to conduct the research, 2) has a protocol under which patient-identifying information will be kept in accordance with the regulations' security provisions (see §2.16), and 3) has provided a written statement from a group of three or more independent individuals who have reviewed the protocol and determined that it protects clients' rights.

Researchers are prohibited from identifying any individual client in any report or otherwise disclosing any client identities except back to the program.

## ***Audit and Evaluation***

Approved entities performing an audit or evaluation (for example, utilization or quality control review) may have access to client records on the program's premises. Approved entities include Federal, State, and local government agencies that fund or are authorized to regulate a program, private entities that fund or provide third-party payments to a program, and peer review entities. Any person or entity that reviews client records to perform an audit or conduct an evaluation must agree in writing that it will use the information only to carry out the audit or evaluation and that it will redisclose client information only 1) back to the program, 2) in accordance with a court order to investigate or prosecute the program (§2.66), or 3) to a government agency overseeing a Medicare or Medicaid audit or evaluation (§2.53(a), (c), (d)).

Approved entities may also copy or remove records but only if they agree in writing to maintain patient identifying-information in accordance with the regulations' security requirements (see §2.16), to destroy all patient-identifying information when the audit or evaluation is completed, and to redisclose client information only 1) back to the program, 2) in accordance with a court order to investigate or prosecute the program (§2.66), or 3) to a government agency overseeing a Medicare or Medicaid audit or evaluation (§2.53(b)).

Any other person or entity determined by the program director to be qualified to conduct an audit or evaluation, and who agrees in writing to abide by the restrictions on redisclosure, can also review client records. However, only approved entities can copy or remove records.

## ***Followup Research***

Research that follows clients for any period of time after they leave treatment presents a special challenge under the Federal regulations. The AOD program, researcher, or evaluator seeking to contact former clients to gain information about their status after leaving treatment has to do so without disclosing to others any information about the clients' connection to the AOD program.

If followup contact is to be attempted over the phone, the program or research entity has to be sure it is talking to the client before it reveals who it is or that there is a connection to AOD abuse treatment. For example, asking for Sally Jones when her husband or child answers the phone and announcing that the caller is from the XYZ AOD Program (or the Drug Research

Corporation) violates the regulations. Another approach is for the program (or research agency) to form another entity, without a hint of AOD treatment in its name (for example, Health Research, Inc.) that can contact clients without worrying about disclosing information via the contact. However, when persons from this entity call clients, they still have to be careful about what they say over the phone and be sure that they are speaking to the client before revealing any connection to AOD abuse treatment.

If followup is to be done by mail, the return address should not disclose any information that could lead someone seeing the envelope to conclude that the former client was in treatment.

## Endnotes

<sup>1</sup>This chapter was written for the consensus panel by Margaret K. Brooks, Esq.

<sup>2</sup>Citations in the form "§2..." refer to specific sections of 42 C.F.R. Part 2.

<sup>3</sup>The results of urine tests performed by AOD programs are protected by the Federal regulations. However, urine testing conducted by criminal justice authorities for the purposes of uncovering illegal drug use or monitoring offenders' compliance with rules against illegal drug use are not protected under the Federal regulations.

<sup>4</sup>Only offenders who have "applied for or received" services from a program are protected. If an offender has not yet been assessed or counseled by a program and has not him- or herself sought help from the program, the program is free to discuss the offender's drug or alcohol problems with others. But, from the time the offender applies for services or the program first conducts an assessment or begins to counsel the offender, the Federal regulations govern.

<sup>5</sup>If the offender is a minor, parental consent must also be obtained in some States.

<sup>6</sup>Note, however, that no information that is obtained from a program (even if the client consents) may be used in a criminal investigation or prosecution of a client unless a court order has been issued under the special circumstances set forth in §2.65. 42 U.S.C. §§290dd-3(c), ee-3(c); 42 C.F.R. §2.12(a),(d).

<sup>7</sup>Once the criminal justice system consent has expired, no further information can be disclosed, unless the offender signs another (noncriminal justice system) consent to release the information (or another of the regulations' exceptions applies). For a discussion of how an AOD assessment or treatment program operating as part of an intermediate sanction can obtain the AOD treatment records that were compiled by an AOD treatment program the offender previously attended, see below.

<sup>8</sup>Suppose the offender had already been sentenced when he or she was assessed by Program A, but is being treated by Program B. Would §2.35(d) permit the probation department to release the assessment to Program B without a separate consent from the offender. It would, since the offender's

criminal justice status would not have changed and it would be doing so "to carry out [its] official duties with regard to ... [the criminal justice status] action in connection with which the consent was given."

<sup>9</sup>When a client enters treatment because of involvement with the criminal justice system, program staff should maintain an open mind about whether communications with an employer would be beneficial to the client. A client who tells program staff that his or her employer will not be sympathetic about the decision to enter treatment may well have an accurate picture of the employer's attitude. Insistence by program staff on communicating with the employer may cost a client his or her job. If such communication takes place without the client's consent, the program may find itself facing an unpleasant lawsuit.

<sup>10</sup>Moreover, the Federal AOD regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hasenie v. United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

<sup>11</sup>Note that the Federal statutes and regulations strictly prohibit any investigation or prosecution of a client based on information obtained from records unless the court order exception is used. 42 U.S.C. §§290 dd-3(c) and ee-3(c) and 42 C.F.R. §2.12(d)(1).

<sup>12</sup>For an explanation about how to deal with subpoenas and search and arrest warrants, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1991 by the Legal Action Center, 153 Waverly Place, New York, 10014.

<sup>13</sup>However, if the information is being sought to investigate or prosecute a patient for a crime, only the program need be notified (§2.65). If the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Appendix A -- Bibliography**

Austin, J., Bloom, B., and Donahue, T.

Female Offenders in the Community: An Analysis of Innovative Strategies and Programs. San Francisco: National Council on Crime and Delinquency, 1992.

Bureau of Justice Statistics, U.S. Department of Justice.

Felony Sentences in State Courts, 1990. Washington, D.C.: Bureau of Justice Statistics, 1991.

Byrne, J.M., Lurigio, A.J., and Baird, C.

The effectiveness of the new intensive supervision programs. In Research in Corrections. Washington, D.C.: National Institute of Corrections and the Robert J. Kutak Foundation, 1987.

Center for Substance Abuse Treatment.

National Task Force on Correctional Substance Abuse Strategies. TIE Communique, Spring 1993.

Colorado Department of Health, Alcohol and Drug Abuse Division.

*Current Findings on Treatment Effectiveness: Questions and Answers.* Denver: Colorado Department of Health, 1992.

Colorado House

Bill 91-1173., 1991.

Colorado Story: Colorado's Cooperative Legislative Plan Linking Substance Abuse Treatment With the Criminal Justice System (unpublished paper).

Rockville, Maryland: Center for Substance Abuse Treatment, 1993.

Freed, D.J., and Mahoney, B.

Between prison and probation: using intermediate sanctions effectively. Judges Journal Winter:1-14, 1990.

Johnson, V.E.

Intervention: How to Help Someone Who Doesn't Want Help. Minneapolis: Johnson Institute Books, 1986.

Keiser, G.M.

Presentation for the Community Justice Resource Center. Greensboro, N.C.: Guilford College, March 5, 1991.

McGarry, P.

Improving the Use of Intermediate Sanctions: Lessons from the Intermediate Sanctions Project. Washington, D.C.: Center for Effective Public Policy, 1992.

Office of Justice Programs.

A Survey of Intermediate Sanctions. Washington, D.C.: U.S. Department of Justice, 1990.

Petersilia, J.

Conditions that permit intensive supervision programs to survive. *Crime & Delinquency* 36(1):126-145, 1990.

Petersilia, J.

Expanding Options for Criminal Sentencing. Santa Monica, California: Rand Corp., 1987

Vidgal, G.L.

Comprehensive Assessment, Diagnosis and Classification: Treatment Matching of Substance Abusing Offenders. Madison: Wisconsin Department of Corrections, 1990.

Vidgal, G.L.

Summary of Uniform Substance Abuse Screening Battery. Madison: Wisconsin Department of Corrections, 1990.

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Appendix B -- Costing Issues**

Calculating the cost of providing alcohol and other drug (AOD) abuse treatment services for offenders in intermediate sanctions programs is an important part of overall program planning and implementation. Data are necessary to determine the costs of various services, so that cost benefits may be analyzed and programs judged in an economic context.

Unfortunately, only a limited amount of data about costing were available in preparing this report, and the data showed a wide range of costs. Individual jurisdictions may find it beneficial to analyze in detail their own current costs in providing AOD abuse treatment services for criminal offenders, so that they can build a database that can be used for future decisionmaking about treatment options and planning treatment programming.

The data include costs for:

- Residential programs
- Outpatient programs
- Day reporting programs
- Detoxification
- Monitoring and drug testing (usually urinalysis).

In one large metropolitan area in the Midwest, residential services provided to 271 offenders over a 1-year period cost \$1,400,149 or \$5,167 per person. These ranged from \$3,564 per person in a transition program to \$7,302 per person in a halfway house.

In a second jurisdiction, a county in the Southwest, the estimated operating costs for community-based residential services for offenders were \$55 to \$95 per client per day, or an annual range of \$20,075 to \$34,675 per client. In this county, costs for residential detoxification were substantially higher, ranging from \$115 to \$130 per day.

Outpatient treatment programs cost considerably less. In the Midwestern metropolitan area, the cost for outpatient services for 61 clients totaled \$31,602, or \$518 per client annually. Day reporting programs cost \$716,130 annually for 359 clients, or \$1,995 per client. A community service program in this jurisdiction cost \$66,667 for 186 clients, or \$358 per client annually. In the county in the Southwest, outpatients costs were provided only for detoxification programs.

These were \$32 per day, at least one-third less than the cost of residential detoxification. However, even in the outpatient setting, detoxification services seem to be significantly more expensive than other types of outpatient services.

A study by Treatment Alternatives to Street Crime (TASC) in another large Midwestern city calculated a per diem client cost of \$5.02 for outpatient services. For the purposes of comparison to the above statistics, this would total \$1,832 per client per year, if services were provided every day of the year. TASC statistics were based on treatment of released offenders who were living in a facility similar to a halfway house and required assessment and case management services. Clients had an average length of stay of 111 days. The cost analysis did not include the costs of urinalysis.

The TASC cost analysis computed that labor costs -- i.e., the cost of the salary of the case manager, plus supervisory costs -- accounted for 65 percent of the total cost of the direct services provided. The remaining 35 percent included direct program expenses such as staff travel, supplies, equipment rental and maintenance, telephone, postage, and facility rental. In addition, 25 percent of the direct service total was budgeted for indirect costs. Thus, based on an average annual case manager salary of \$20,000, plus \$5,400 for fringe benefits, costs were:

- Labor: \$25,400
- Supervision: \$2,540
- Nonlabor costs: \$9,779
- Indirect costs: \$9,430.

TASC based its per client, per diem costs on a 40-client caseload, and 235 days of service in 1 year.

TASC also calculated per diem per client costs in other cities around the country. The lowest cost, \$5, found was in a large Northeastern city. In a Southern city the per diem per client cost was \$5.50. It was \$7.50 in a Southwestern city, and it ranged from \$5 to \$10 in a State in the Northwest.

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Appendix C -- Cultural Competence**

The definitional material below was adapted from *Towards a Culturally Competent System of Care*, by T.L. Cross, B.J. Bazron, K.W. Dennis, and M.R. Isaacs, 1989 (available from the Georgetown University Child Development Center, Washington, D.C.). The Cultural Competence Checklist is adapted from a questionnaire by Drs. George Simons and Bob Abramms entitled Managing the Dominant Culture, which appears in *The Questions of Diversity, 5th Edition*, copyright 1992, ODT, Inc., Amherst, Massachusetts (all rights reserved; reproduced with permission). It is available from ODT.

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to work effectively in cross-cultural situations. Cultural competence acknowledges and incorporates, at all levels, the importance of culture, the assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. It is born of commitment to provide quality services to all and a willingness to risk.

### **Continuum of Competence**

**Cultural destructiveness** -- Attitudes, policies, and practices that are destructive to cultures and individuals within cultures. (Disenfranchisement, control, exploitation, destruction of cultural systems.)

**Cultural incapacity** -- The systems or agencies do not intentionally seek to be culturally destructive, but rather lack the capacity to help. (Discriminatory hiring, subtle messages regarding what values should be, lower expectations for minority clients.)

**Cultural blindness** -- Color or culture make no difference. All people are the same. Approaches are universal. Services are so ethnocentric as to be useless

to all but the most assimilated people of color. (Ignore cultural strengths, encourages assimilation, blames the victims, eligibility for services equals assimilation.)

**Cultural precompetence** -- Implies movement. Realizes weaknesses and makes attempts to improve. False sense of movement and accomplishment. One goal equals enough. Tokenism.

**Cultural competence** -- Acceptance, respect for differences. Attention to dynamics of differences. Continuous expansion of cultural knowledge. Groups are different with diverse subgroups. Seeks consultation from people of color. Hires those committed to their community. Provides support to staff to become comfortable working in cross-cultural situations. Understands interplay between policy and practice. Committed to policies that enhance diverse clientele and services.

**Cultural proficiency** -- Holds cultures in high esteem. Conducts research, develops new therapeutic approaches based on cultures. Publishes and distributes information. Hires staff who are specialists in culturally competent practice. Advocates for culturally competent practice. Advocates for cultural competence throughout the system and society.

### **Cultural Competence and Proficiency**

- Attitudes are less ethnocentric and biased.
- Policies are more flexible and culturally impartial.
- Practices are more congruent with the culture of client from initial contact to assessment.
- The system:
  - Values diversity and respects its worth.
  - Culturally assesses itself.
  - Understands the dynamics of difference
  - Institutionalizes the value of both cultural competence and cultural proficiency.
  - Adapts to diversity.
  - Has a value base for both.
  - Incorporates valid research into the care process.

#### **Cultural Competence Checklist**

Check the items which are true of you.

Hint: The more true, the better! However, don't kid yourself about how well you see yourself perform in these areas. Get feedback from others as well as rating yourself.

#### **When I belong to the dominant culture:**

- I am aware that I am part of a dominant culture, and know how its dynamics work. I listen to people of other cultures when they tell me how my culture affects them.

- I have a philosophy of fairness and I let others in my culture know about my commitment.
- I realize that people of other cultures have fresh ideas and different perspectives to bring to my life and my organization.
- I work to make sure that members of other cultures are heard and are respected for their differences.
- I coach others on how to succeed in my culture. I tell them the unwritten rules and show them what they need to do in order to function better.
- I ensure that my subordinates and colleagues from other cultures are prepared for what they have to do to meet the demands of my culture.
- When I train or coach others, I do not put them down or undermine the value of their differences.
- I give others my personal support and loyalty even if they are rejected or criticized by members of my culture.
- I am aware that outsiders to my culture recognize my cultural peculiarities better than I do and I go to them for information about the effect of things that I do and say.
- I recognize how stress causes individuals to revert to older and narrower beliefs and the desire to make oneself and one's culture right and others wrong.
- I apologize when I have done something inappropriate that offends someone of a different background.
- When answerable to or reporting to someone of a different culture, I deal directly with that person and avoid the tendency to "go over his or her head" to a person of my own culture.
- I make others aware of unfair traditions, rules, and ways of behaving in my culture or organization that keep them out.
- I acknowledge people for what they have accomplished in terms that make them feel recognized in their own right, not just because they have been useful to me.
- I resist the temptation to make another group the scapegoat when something goes wrong.
- I give others honest yet sensitive feedback about how they perform on the job. I have learned to give feedback to people of other cultures in a way that is sensitive yet clear and useful.
- I distribute information, copies, results, etc., to whomever should get them regardless of cultural differences.
- I go out of my way to recruit, select, train, and promote people from outside the dominant culture. Despite the fact that I may naturally feel less comfortable with them, I see this as one of my responsibilities as a manager.

#### **When I don't belong to the dominant culture:**

- I realize that, because of my background, I have something distinctive to contribute to the place or organization in which I find myself.
- Even when rejected, I take pride in my culture. I take steps to build my self-esteem and the self-esteem of others who, like me, do not belong to the dominant culture.
- While I know that I do not have to lose my cultural distinctiveness to fit in, I realize that I may have to learn new information and skills that will enable me to succeed in the dominant culture.
- I look for and cultivate relationships with members of the dominant culture who help me "read between the lines" to understand the unwritten rules about "how the system works."
- When I succeed in the dominant culture, I am careful not to make myself an exception or separate myself from others of my background.

- I share what I learn about the dominant culture with others like myself.
- I recognize that when under pressure, I tend to revert to older and narrower beliefs and want to make myself and my culture right and others wrong.
- I sympathize and collaborate with other nondominant groups to achieve common objectives in the dominant culture.
- I resist the inclination to cluster *exclusively* with my own kind of people or *exclusively* with people from the dominant culture when I am in mixed company.
- I resist blaming the dominant group for everything that goes wrong.
- I know how to present distinctive features of my culture and its points of view in ways that others can hear and understand.
- I can respect individuals of other cultures and treat them fairly even though I may be fiercely committed to conflicting political goals.
- I know how to refresh myself from the wellsprings of my own culture when I am exhausted by trying to understand and work in the dominant culture.
- I resist the temptation to make another group the scapegoat when something goes wrong.

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Appendix D -- Federal Resource Panel**

Robert Anderson

Director

Criminal Justice Services

National Association of State Alcohol and Drug Abuse Directors

Robert B. Aukerman

Director

Alcohol and Drug Abuse Division

Colorado Department of Health

Duiona R. Baker, M.P.H.

Public Health Advisor

Quality Assurance and Evaluation Branch

Division of State Programs

Center for Substance Abuse Treatment

Virginia Brooks Baldauf

Director

Research Applications and Training Division

National Institute of Justice

U.S. Department of Justice

Steve Bocian

Deputy Director  
Governor's Office of Justice Assistance  
Baltimore, Maryland

Jim Brennan  
Staff Associate

National Association of Social Workers

Fulton Caldwell, Ph.D.  
Health Scientist Administrator  
National Institute on Alcohol Abuse and Alcoholism

Diane Canova, J.D.  
Executive Director  
Therapeutic Communities of America  
Arlington, Virginia

Judge Elbridge Coochise  
President  
National American Indian Court  
Judge Association  
Northwest Intertribal Court System  
Edmonds, Washington

Mark Cunniff  
Executive Director  
National Association of Criminal Justice Planners  
Dorynne Czechowicz, M.D.  
Associate Director  
Medical and Professional Affairs

Division of Clinical Research

National Institute on Drug Abuse

Peter Delany, M.S.W.

Project Officer

Treatment Research Branch

National Institute on Drug Abuse

Richard Dembo, Ph.D.

Professor of Criminology

University of South Florida

Tampa, Florida

John Gregrich

Senior Policy Analyst

Office for National Drug Control Policy

Executive Office of the President

James Inciardi, Ph.D.

Professor and Director

Center for Drug and Alcohol Studies

University of Delaware

Newark, Delaware

Nolan Jones, Ph.D.

Director of Justice and Public Safety

National Governor's Association

Sandra H. Kerr

Public Health Analyst

Division of STD/HIV Prevention

Behavior and Prevention Research Branch

National Center for Prevention Services

Centers for Disease Control and Prevention

Charlene Lewis, Ph.D.

Chief

Program Evaluation Branch

Office of Scientific Analysis and Evaluation

Center for Substance Abuse Treatment

Anna Marsh, Ph.D.

Associate Director for Evaluation

Office of Applied Studies

Center for Substance Abuse Treatment

Ann McDiarmid, Esq.

Community Corrections Specialist

National Institute of Corrections

Peggy McGarry

Senior Associate

Center for Effective Public Policy

Washington, D.C.

Roberta Messalle

Public Health Advisor

Quality Assurance and Evaluation Branch

Division of State Programs

Center for Substance Abuse Treatment

Marilyn Rice, M.A., M.P.H., C.H.E.S.

Deputy Director

National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs

Barbara Roberts, Ph.D.

Policy Analyst

Demand Reduction Office

Office for National Drug Control Policy

Executive Office of the President

Marilyn McCoy Roberts

Senior Staff Associate

National Center for State Courts

Steven J. Shapiro

Public Health Advisor

Criminal Justice Branch

Division of National Treatment Demonstrations

Center for Substance Abuse Treatment

Brenda Smith, Esq.

Senior Council/Economic Security

National Women's Law Center

Philip Toelkes

Program Manager

State Justice Institute

Steven Valle, Sc.D., M.B.A., N.C.A.C.

National Association of Alcoholism and Drug Abuse Counselors

Gerald L. Vigdal, M.S.W., B.C.D.

Office Director

Office of Drug Abuse

Division of Program Services

Wisconsin Department of Corrections

Ellen Weber, Esq.

Legal Counsel

Legal Action Center

Beth Weinman

National Drug Abuse Coordinator

Psychology Branch

Federal Bureau of Prisons

Cecelia Willis, M.D.

National Black Alcoholism Council

John Zachariah

Regional Administrator

American Correctional Association

# **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**

## ***Treatment Improvement Protocol (TIP) Series 12***

### **Appendix E -- Field Reviewers**

Robert E. Anderson

Director

Criminal Justice Programs

National Association of State Alcohol and Drug Abuse

Mary Jane Argento, Ph.D.

Norman Alcohol and Drug Treatment Center

Griffin Memorial Hospital

Oklahoma Department of Mental Health and Substance Abuse Services

Richard Asarian, Ph.D.

Director/Psychologist

Mon-Yough Ielase Institute

Pittsburgh, Pennsylvania

W. Chester Bell, M.P.A.

Associate Executive Director

Stewart Marchman Center

Daytona Beach, Florida

Stephen A. Bocian

Executive Director

Governor's Office of Justice Assistance

Baltimore, Maryland

Dan Cain

Executive Director

Eden Programs, Inc.

Minneapolis, Minnesota

Matthew Cassidy

Associate Executive Director

EAC, Inc.

Carle Place, New York

Sandra Clunies, M.S., N.C.A.D.C.

Public Health Advisor

Quality Assurance and Evaluation Branch

Division of State Programs

Center for Substance Abuse Treatment

Lori-Ann Costantino

Executive Director

Bridges of America

Florida Alcohol and Drug Abuse Association

American Correctional Association

Mark Cunniff

Executive Director

National Association of Criminal Justice Planners

Peter J. Delany, D.S.W.

Social Science Analyst

Division of Clinical Research

National Institute on Drug Abuse

Mark P. Fontaine, M.S.W., C.A.P., C.C.J.A.P.

Assistant Director

Florida Alcohol and Drug Abuse Association

Tallahassee, Florida

Leon Gillis, III

Executive Director

Anti-Recidivist Effort, Inc.

Daytona Beach, Florida

R. John Gregrich

(Acting) Deputy for Demand Reduction

Office for National Drug Control Policy

Executive Office of the President

Donald Lee Harris, Jr.

Director of Field Services

Tennessee Department of Corrections

Walter Helton, M.Div.

Executive Director

The Recovery Partnership, Inc.

Raleigh, North Carolina

Jeff A. Hoffman, Ph.D.

Vice President of Operations

Center for Drug Treatment and Research

KOBA Institute

Washington, D.C.

Dennis A. Humphrey, Ed.D.

Executive Director

Massachusetts Committee on Criminal Justice

Robbie M. Jackman, M.S.S.W.

Assistant Commissioner

Bureau of Alcohol and Drug Abuse Services

Tennessee Department of Health

Nolan E. Jones, Ph.D.

Director

Justice and Public Safety

National Governor's Association

James Kendrick, M.A., C.S.W.

Director

Specialty Program in Alcohol and Drug Abuse

University Substance Abuse Clinic

Ellsworth Hall

Western Michigan University

Kalamazoo, Michigan

Geoffrey Laredo, M.P.A.

Senior Program Analyst

Office of the Administrator

Office of Policy and Program Coordination

Division of Planning and Policy Implementation

Substance Abuse and Mental Health Services Administration

Linda Loffredo

Education Associate

Office of the Deputy Chancellor

New York City Board of Education

Doris L. MacKenzie, Ph.D.

Research Scholar

Department of Criminal Justice and Criminology

University of Maryland

College Park, Maryland

Jane H. Martin, M.B.A.

Director

Risk Reduction Programs

Substance Abuse Services Section

Division of Mental Health, Mental

Retardation, and Substance Abuse

Department of Human Resources

Atlanta, Georgia

Sue Martone, B.A.S.W., M.P.A.

Legislative Analyst

Office of the Administrator

Substance Abuse and Mental Health Services Administration

James C. May, Ph.D.

Substance Abuse Director

City of Richmond Department of Mental Health, Mental Retardation, and Substance Abuse Services

Richmond, Virginia

Roberta Messalle

Senior Advisor

Criminal Justice Linkages

Quality Assurance and Evaluation Branch

Division of State Programs

Center for Substance Abuse Treatment

Harry W. Moffett

Senior Human Services Specialist

Department of Health and Rehabilitation Services

Tallahassee, Florida

Mickey M. Neel, N.C.A.D.C., N.C.A.C.II

Texas Department of Criminal Justice

Community Justice Assistance Division

Richard J. Nimer, M.A., C.J.C.A.P.

Correctional Programs Administrator

Florida Department of Corrections

Margo L. Parisi, M.S.S.W.

Executive Director

Drug Abuse Comprehensive Coordinating Office

Tampa, Florida

Roger H. Peters, Ph.D.

Assistant Professor

Florida Mental Health Institute

Department of Law and Mental Health

University of South Florida

Tampa, Florida

Sheryl Pimlott, M.S.W.

Project Director

Project Transition

Women and Infants at Risk

Michigan Department of Corrections

Nancy G. Radford, M.C.J., C.C.J.A.P., C.A.A.P.

Associate Executive Director

River Region Human Services, Inc.

Jacksonville, Florida

Marilyn Rice, M.A., M.P.H., C.H.E.S.

Project Director

National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs

Center for Substance Abuse Prevention

Barbara T. Roberts, Ph.D.

Public Health Advisor

Division of National Treatment Demonstrations

Center for Substance Abuse Treatment

Marilyn McCoy Roberts

Deputy Director, Washington Office

National Center for State Courts

Mark Schuettinger, L.S.A.C.

Program Coordinator

Amity, Inc.

Rayson, Arizona

Mary Ann Shaening, Ph.D.

Director

Shaening and Associates

Santa Fe, New Mexico

Steven J. Shapiro

Public Health Advisor

Division of National Treatment Demonstrations

Criminal Justice Systems Branch

Center for Substance Abuse Treatment

Rose Soo Hoo, M.S.W., M.B.A.

Administrator

King County North Rehabilitation Facility

Washington State Council on Alcohol and Drug Dependency

Geraldine Sylvester

Director

New Hampshire Office of Alcohol and Drug Abuse

Sushma D. Taylor, Ph.D.

Executive Director

Center Point, Inc.

San Rafael, California

Barbara Hanson Treen

Commissioner

New York State Board of Parole

Stephen K. Valle, Sc.D., M.B.A.

President and CEO

Right Turn, Inc. and Valle Management Associates

Lynn, Massachusetts

Gerald L. Vigdal, M.S.W., B.C.D.

Director

Office of Drug Abuse

Division of Program Services

Wisconsin Department of Corrections

Cheryl Clark Walker, M.P.A.

Program Consultant

Substance Abuse Program Section

Michigan Department of Corrections

# Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System

## *Treatment Improvement Protocol (TIP) Series 12*

### [Exhibits]

#### Exhibit 1-1: Forms of Intermediate Sanctions

- **Means-based fines (also called "day" fines).** The total amount of these fines is calibrated to both the severity of the crime and the discretionary income of the offender, with the calibration and calculation established by the court as a whole for all cases in which this type of fine is to be imposed. (This is in contrast to traditional fines that are imposed at the discretion of the judge according to ranges set by the legislature for particular offenses.) Defendants with more income (and/or fewer familial obligations) pay a higher overall fine than those with lower incomes (and/or more obligations) for the same crime. This approach to setting the fine amount is typically coupled with expanded payment options and tighter collection procedures.
- **Community service.** This is the performance by offenders of services or manual labor for government or private, nonprofit organizations for a set number of hours, with no payment. Community service can be arranged for individuals, case by case, or organized by corrections agencies as programs. For example, a group of offenders can serve as a work crew to clean highways or paint buildings.
- **Restitution.** Restitution is the payment by the offender of the costs of the victim's losses or injuries and/or damages to the victim. In some cases, payment is made to a general victim compensation fund; in others, especially where there is no identifiable victim, payment is made to the community as a whole (with the payment going to the municipal or State treasury).
- **Special needs probation programs or caseloads.** In these approaches to intermediate sanctions, officers with special training carry a restricted caseload. Typically, these approaches are used with offenders who have committed some categories

of domestic violence, sex offenses, and driving under the influence, and with mentally ill, developmentally disabled, or substance-abusing offenders. Supervision in a specialized caseload may mean more intensive or more intrusive supervision than in routine caseloads, the provision of enhanced social and psychological services, and/or specific training or group activities, such as anger management classes or victim impact meetings.

- **Outpatient or residential AOD abuse treatment centers.** Both public and private treatment centers may be contracted to provide treatment to offenders, as described in this TIP.
- **Day centers or residential centers for other types of treatment or training.** These centers are established to provide services other than AOD abuse treatment. For example, a center may provide skills training to enhance offenders' employability.
- **Intensive supervision probation.** The level and types of supervision that are labelled intensive vary widely, but usually involve closer supervision and greater reporting requirements than regular probation for offenders. This can range from more than five contacts a week to fewer than four per month. It usually entails other obligations (to attend school, have a job, participate in treatment, or the like). *Intensive supervision parole* has similar requirements -- and variations -- but is provided usually by parole agents to offenders who have completed a prison term and who are serving the balance of their sentence in the community.
- **Day reporting centers.** Under the terms of this intermediate sanction, offenders must report to the center for a certain number of hours each day, and/or report by phone throughout the day from a job or treatment site, as a means of monitoring and incapacitating them.
- **Curfews or house arrest (with or without electronic monitoring).** Offenders are restricted to their homes for various durations of time, ranging from all the time to all times except for work or treatment hours, with a few hours for recreation. Frequently the curfew or house arrest is enforced by means of an electronic device worn by the offender which can alert corrections officials to his or her unauthorized absence from the house.
- **Halfway houses or work release centers.** Offenders in these centers can leave for work, school, or treatment, but are

otherwise restricted to the facility. The facility can be in the community or attached to a jail or similar institution.

- **Boot camps.** Typically, a sentence to a boot camp (also called shock incarceration) is for a relatively short time (3 to 6 months). As the name implies, boot camps are characterized by intense regimentation, physical conditioning, manual labor, drill and ceremony, and military-style obedience. (Because boot camps are a form of incarceration, some in the criminal justice field reject their inclusion in the category of intermediate sanctions. Others include boot camps because placement in them is intended to take the place of a longer, traditional prison term.)

### Exhibit 5-1: Components of an Agreement Between the Treatment Agency and the Criminal Justice Agency

- A. A description of the range of intermediate sanctions that will be used and the level of treatment that will accompany the sanctions:
  1. Information about the duration of the various criminal justice sanctions and the duration of treatment;
  2. A description of the content of treatment: what the treatment will entail.
- B. A description of information that will be shared by the treatment program and the criminal justice agencies:
  1. A specific description of circumstances (such as absconding) when it will be the treatment program's responsibility to notify the criminal justice agency;
  2. Definition of a regular period of reevaluation and identification of the system that will conduct and document the reevaluation.
- C. Identification of which agency will supply ancillary services to the client group.
- D. A description of responses to compliance with treatment and/or sanctions and identification of which agency will decide the consequences of each noncompliant behavior:
  1. A description of the consequences of noncompliant behavior such as:
    - i. Unwillingness to commit to treatment and/or participate in the treatment program
    - ii. Drug-positive results
    - iii. Absconding
    - iv. Other issues: violence, sex, etc.;
  2. Identification of the agency that will decide the consequences of each noncompliant behavior.

### Exhibit 5-2: Items in the Client Agreement

- A description of the treatment program:
  - Duration of treatment
  - Intensity or level of treatment
  - -Components and stages of treatment.

- Categories and consequences of misconduct:
  - Rules of the treatment program and consequences of violating the rules
  - Consequences of AOD relapse
  - Consequences of absconding
  - Consequences of violations of probation or parole conditions.
- Information to be disclosed by the treatment program to the criminal justice system:
  - The types of information disclosed
  - When the disclosures are made
  - The client's signature permitting the disclosures as provided for by Federal confidentiality laws and regulations.
- Discharge criteria.

### **Exhibit 5-3: Positive Incentives for Treatment and Consequences of Negative Behavior**

#### **Positive Incentives:**

- Exposure to models of success
- Small successes to counteract clients' experience of failure, including ceremonial acknowledgments of clients' accomplishments
- Favorable criminal justice outcomes: the promise of some reduction or modification in the duration or intensity of the overall sanction
- Positive program elements that respond to clients' specific needs, including referrals for ancillary services such as:
  - Housing
  - Vocational/educational training
  - Primary health care
  - Employment.

#### **Consequences of Negative Behavior:**

- Clear consequences for infractions
- Consistent enforcement of rules and application of consequences.

### **Exhibit 7-1: Consent for the Release of Confidential Information: Criminal Justice System Referral**

I, \_\_\_\_\_, hereby consent to

Name of defendant)

communication between \_\_\_\_\_ and

Treatment program)

Court, probation, parole, and/or other referring agency)

the following information: \_\_\_\_\_

Nature of the information, as limited as possible)

The purpose of and need for the disclosure is to inform the criminal justice agenc(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

---

---

I understand that this consent will remain in effect and cannot be revoked by me until:

There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

---

Other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records and that recipients of this information may redisclose it only in connection with their official duties.

---

Date(Signature of defendant/patient)

---

Signature of parent, guardian, or

authorized representative if required)

### **Exhibit 7-2: Consent for the Release of Confidential Information**

I, \_\_\_\_\_, authorize

Name of patient)

---

(Name or general designation of program making disclosure)

to disclose to \_\_\_\_\_

(Name of person or organization to which disclosure is to be made)

the following information: \_\_\_\_\_

Nature of the information, as limited as possible)

---

---

The purpose of the disclosure authorized herein is to: \_\_\_\_\_

---

---

(Purpose of disclosure, as specific as possible)

---

---

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

---

---

(Specification of the date, event, or condition upon which this consent expires)

Dated: \_\_\_\_\_

Signature of participant)

\_\_\_\_\_  
Signature of parent, guardian, or

authorized representative when required

### **Exhibit 7-3: Prohibition on Rediscovering Information Concerning AOD Abuse Treatment Patients**

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

### **Exhibit 7-4: Qualified Service Organization Agreement**

XYZ Service Center ("the Center") and the \_\_\_\_\_  
\_\_\_\_\_

(Name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide the following services:  
\_\_\_\_\_

(Nature of services to be provided)

\_\_\_\_\_  
\_\_\_\_\_

Furthermore, the Center:

1. Acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the patients in the Program, it is fully bound by the provisions of the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and
2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the Federal confidentiality regulations, 42 CFR Part 2.

Executed this \_\_\_\_ day of \_\_\_\_\_, 199\_\_.

---

President  
XYZ Service Center  
(Address)

---

Program Director  
(Name of Program)  
(Address)